

# The State of Delaware

## FY19 Planning

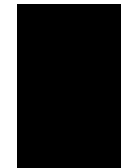
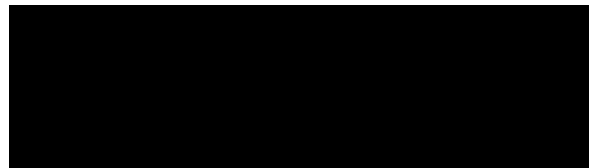
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October 23, 2017

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## Refocusing on the Long Term Plan



# GHIP long term health care cost projections

- As discussed in the September 25, 2017 SEBC meeting, GHIP Fund Equity balance as of 6/30/2017 is \$102.7m with \$25m surplus, projected to increase to \$36m by end of FY18
- Current GHIP surplus will be eroded if revenue growth (i.e., increases to premium contributions) does not keep pace with expected increases in health care expenditures
- The “no change” long term health care cost projections on the following page has been updated to reflect the potential impact of the ACA excise tax (“Cadillac” tax)
  - Despite efforts to repeal, excise tax is still slated to take effect in 2020, with regulatory guidance pending
  - Absent program changes, GHIP excise tax liability projected to be \$0.2m in the second half of FY20 and \$4.0m in FY21 assuming 6% annual health care trend
    - Assumes excise tax calculated based on expected plan expenditures and not premium equivalent rates

# GHIP long term health care cost projections

## No Program Changes

GHIP Costs (\$ millions)	FY17 Actual	FY18 Projected	FY19 Projected	FY20 Projected	FY21 Projected	FY22 Projected	FY23 Projected
<b>GHIP Revenue</b>							
Premium Contributions (No Change) <sup>1</sup>	\$799.0	\$810.3	\$810.3	\$810.3	\$810.3	\$810.3	\$810.3
Other Revenues <sup>2</sup>	\$81.6	\$85.1	\$87.3	\$91.7	\$96.3	\$101.1	\$106.2
<b>Total Operating Revenues</b>	<b>\$880.6</b>	<b>\$895.4</b>	<b>\$897.6</b>	<b>\$902.0</b>	<b>\$906.6</b>	<b>\$911.4</b>	<b>\$916.5</b>
<b>GHIP Expenses (Claims/Fees)</b>							
Operating Expenses (No Change) <sup>3</sup>	\$816.8	\$881.5	\$937.5	\$984.5	\$1,032.7	\$1,084.3	\$1,137.5
<i>Excise Tax Liability<sup>4</sup></i>	-	-	-	\$0.2	\$4.0	\$9.1	\$16.3
<b>Adjusted Net Income (Revenue less Expense/Excise Tax)</b>	<b>\$63.8</b>	<b>\$13.9</b>	<b>(\$39.9)</b>	<b>(\$82.7)</b>	<b>(\$130.1)</b>	<b>(\$182.0)</b>	<b>(\$237.3)</b>
Balance Forward	\$38.9	\$102.7	\$116.6	\$76.7	(\$6.0)	(\$136.1)	(\$318.1)
Ending Balance	\$102.7	\$116.6	\$76.7	(\$6.0)	(\$136.1)	(\$318.1)	(\$555.4)
- <i>Less Claims Liability<sup>5</sup></i>	\$54.0	\$56.5	\$60.1	\$63.1	\$66.2	\$69.5	\$72.9
- <i>Less Minimum Reserve<sup>5</sup></i>	\$24.0	\$24.0	\$25.5	\$26.8	\$28.1	\$29.5	\$30.9
<b>GHIP Surplus (After Reserves/Deposits)</b>	<b>\$24.7</b>	<b>\$36.1</b>	<b>(\$8.9)</b>	<b>(\$95.9)</b>	<b>(\$230.4)</b>	<b>(\$417.1)</b>	<b>(\$659.2)</b>

Note: FY17 Actual based on final June 2017 Fund Equity report and FY18 Projected based on final approved budget as of 8/26/2017 and FY18 elections as of June 2017.

<sup>1</sup> Includes State and employee/pensioner premium contributions and assumes no increase to premiums 7/1/2017 and beyond.

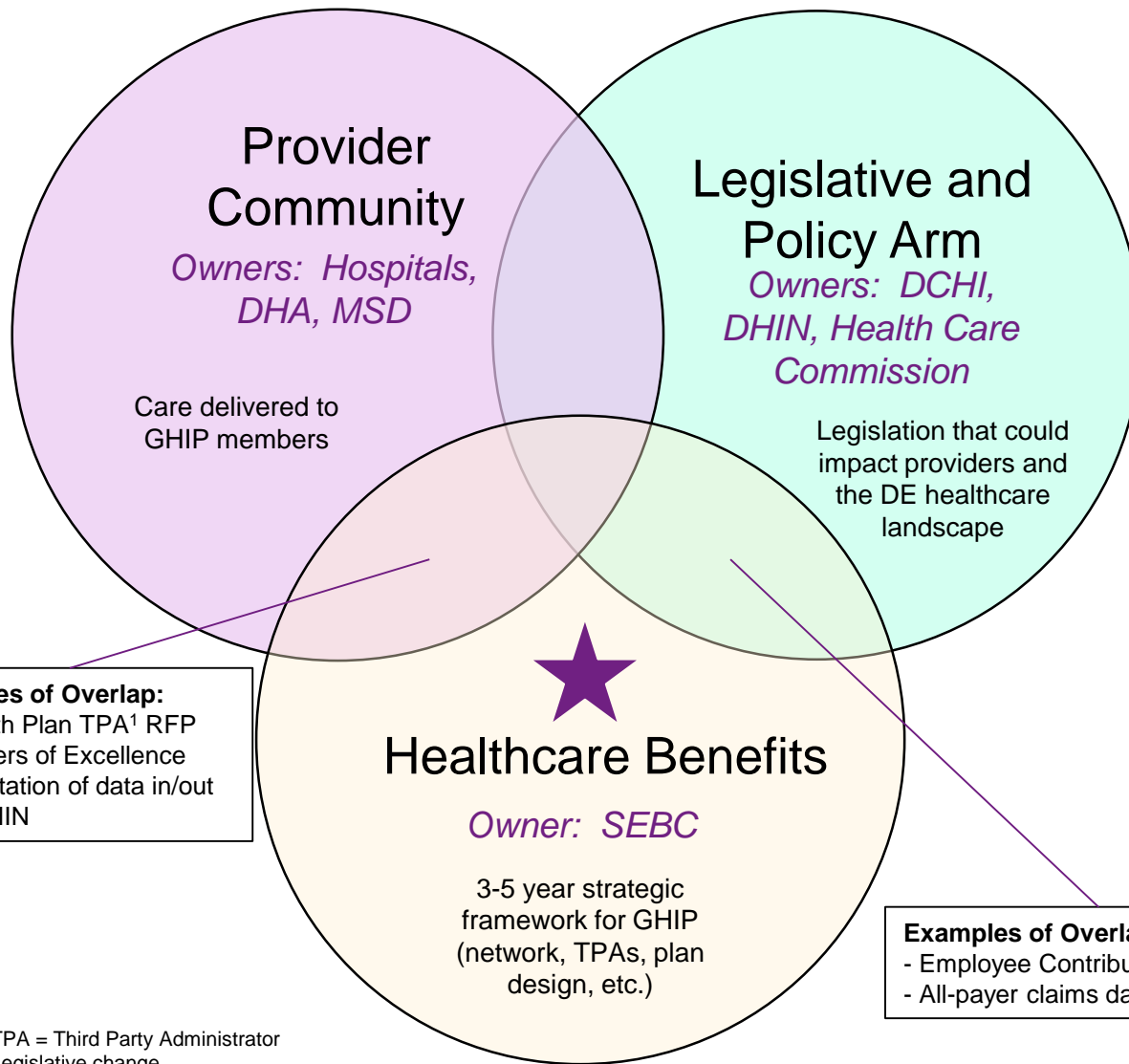
<sup>2</sup> Includes Rx rebates, EGWP payments, participating group fees, and other revenues.

<sup>3</sup> FY19 expenses based on 24-months of claims experience through June 2017, preliminary trend assumptions, year 2 ESI contract savings, and savings from initiatives adopted 7/1/2017. FY20-FY23 projected assuming 5% annual increase over FY19 (6% health care trend less 1% reduction).

<sup>4</sup> 40% excise tax on the value of employer sponsored health care coverage over specified thresholds starting CY 2020. Threshold assumed to increase at 2% annually

<sup>5</sup> Claims Liability and Minimum Reserve levels shown to increase with overall GHIP expense growth for FY19-FY23.

# Key influencers on GHIP



- The role of the SEBC is closely aligned with managing the healthcare benefits programs offered to employees and pensioners
- Outside of the SEBC, there are many stakeholders, of which, two are identified here, that have partial overlap with the committee: the provider community and the legislative and policy arm of the State of Delaware

<sup>1</sup> TPA = Third Party Administrator

<sup>2</sup> Legislative change

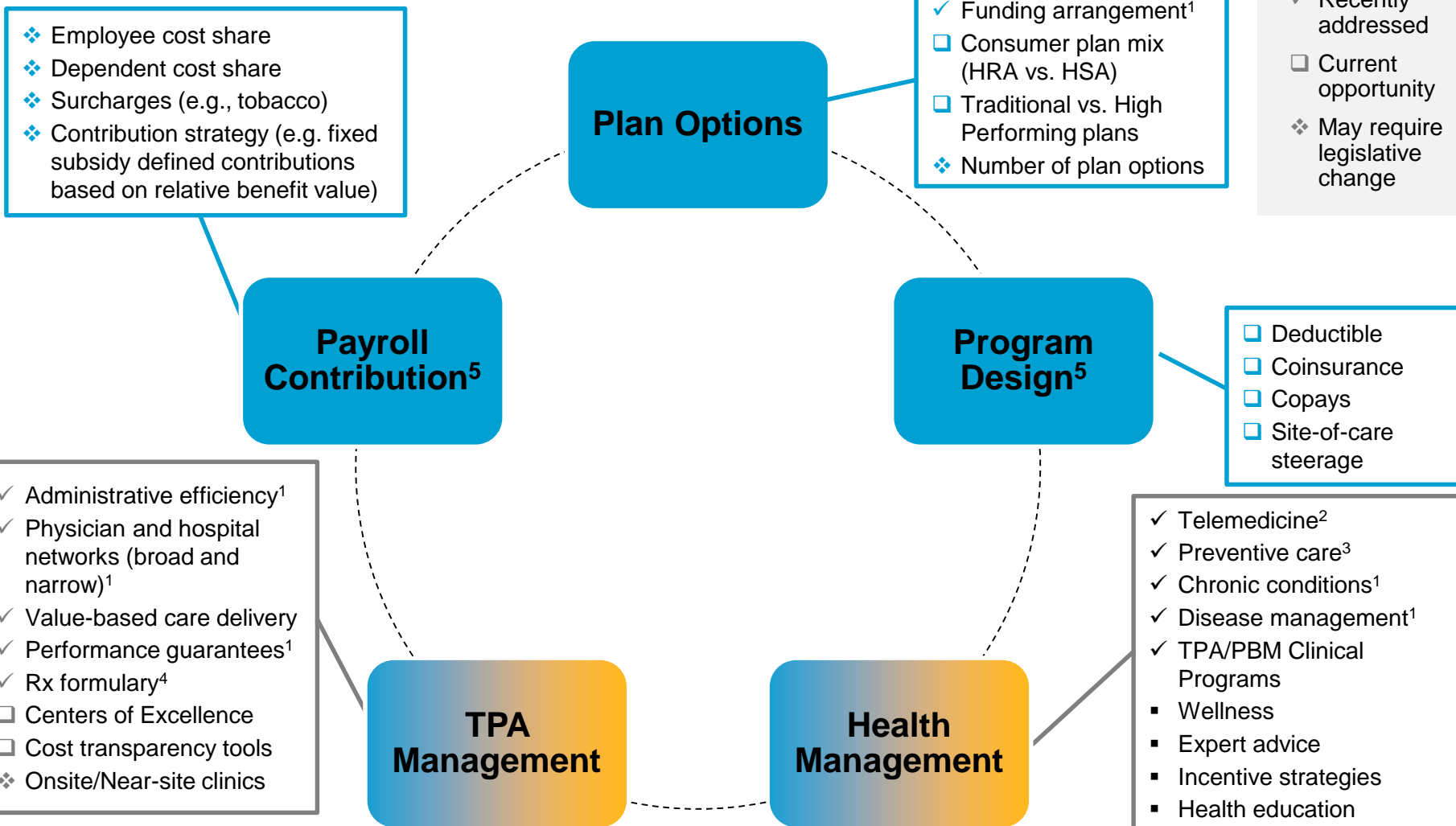
# GHIP influencing levers

Tactics for affecting change and “shrink the pie”

- Supply
- Demand

## Key to Bullets:

- ✓ Recently addressed
- Current opportunity
- ❖ May require legislative change



<sup>1</sup> Medical TPA RFP conducted in FY17.

<sup>2</sup> Implemented effective 7/1/16.

<sup>3</sup> Covered at 100% plan paid in network.

<sup>4</sup> Updated quarterly by Express Scripts.

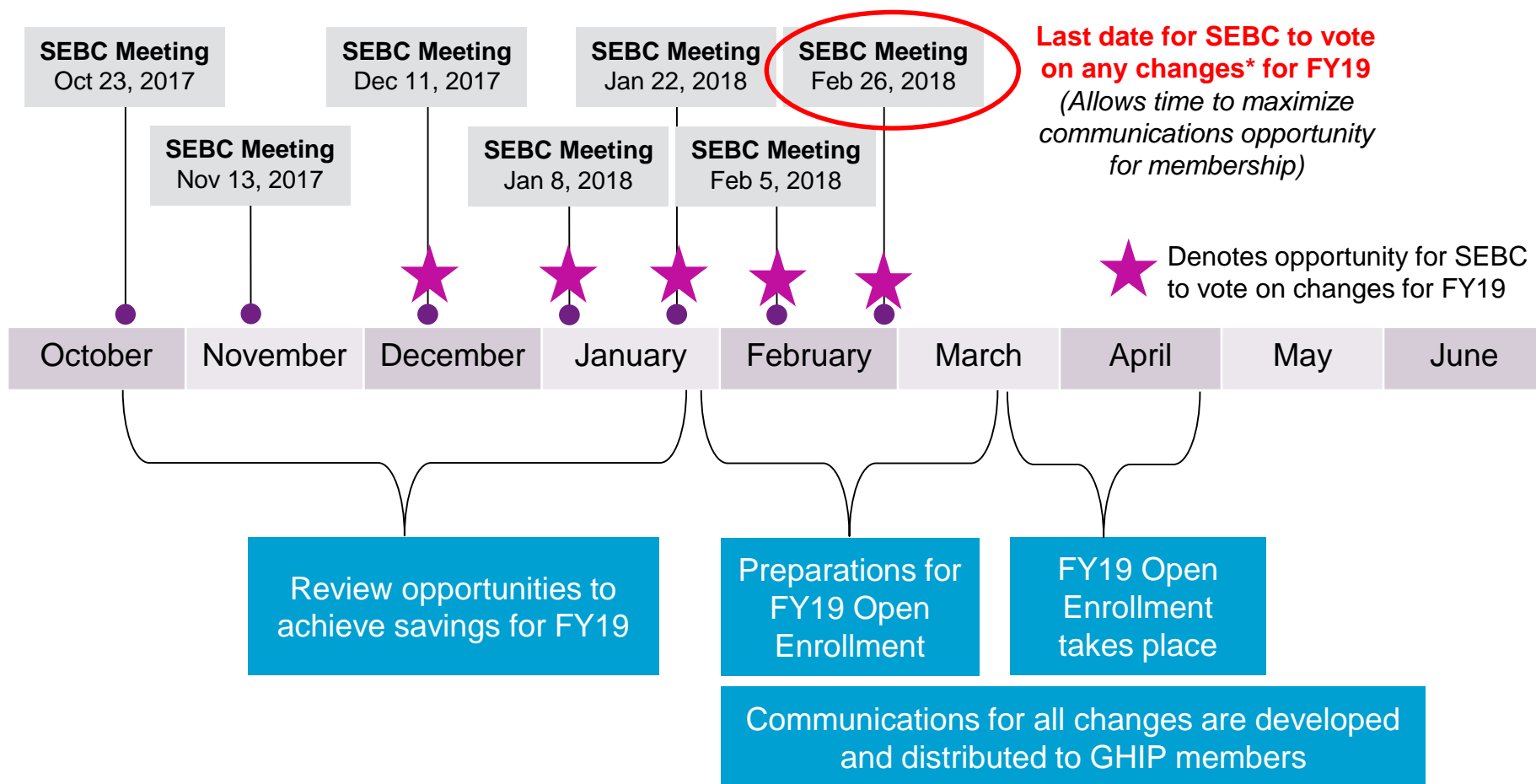
<sup>5</sup> Tactics for affecting change in these categories may increase employee/pensioner share, with the goal of shrinking the pie overall

## Summary of savings opportunities

A sampling of ways to “shrink the pie”

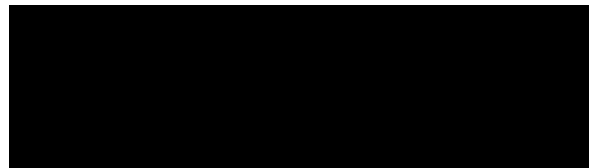
Savings Opportunity	GHIP Goal	Member Impact		Savings Potential (General Fund) (12 months)
		Requires education or engagement?	Scope of potential impact	
Site-of-service steerage	○	Yes – Must know to use designated site of care	No negative impact to member cost if member utilizes designated site of care	\$0.8m - \$2.5m
Centers of Excellence	■ ○	Yes – Must know to use designated site of care	No negative impact to member cost if member utilizes designated site of care	\$3.2m
Reference based pricing	○	Yes – Must be aware of “reference price” for particular service and associated provider pricing	Potential for members to be balance billed for costs in excess of “reference price”	Up to \$1.9m
Cost transparency tools	○ ▲	Yes – Must be aware such tool exists in order to benefit from it. For the State, plan design changes would be a significant driver of member utilization	No negative impact to member cost if member doesn’t use tool	TBD based on degree of member engagement / utilization
Tobacco surcharges <sup>1</sup>	○	Maybe – Depends on “default” option if member doesn’t self-identify as tobacco user	Tobacco users would pay higher payroll contributions as a result of their tobacco use	Up to \$5.3m
Implement HSA plan	○ ▲	Yes – Requires all employees to understand this plan option’s impact on their total out-of-pocket costs as influencer of which option is elected. For enrollees, requires understanding of how the plan works (including the HSA)	For those enrolled in the plan, potential for higher member out-of-pocket cost sharing at point of care; and ability to leverage tax-advantaged account (HSA) to save and pay for medical expenses.	TBD based on enrollment and final plan design
Plan design changes for current plans	○	Yes – Employees need to be aware of plan design changes and how those would affect their out-of-pocket cost for coverage under each plan option	Potential for higher member out-of-pocket cost sharing at point of care	Up to \$23.3m <sup>2</sup>
Active benefits enrollment	▲	Yes – Must complete enrollment process or risk being defaulted into alternative plan option	Would affect all benefits-eligible employees/retirees who do not take action during Open Enrollment	TBD based on default option

# Focal points for the SEBC – planning for FY19

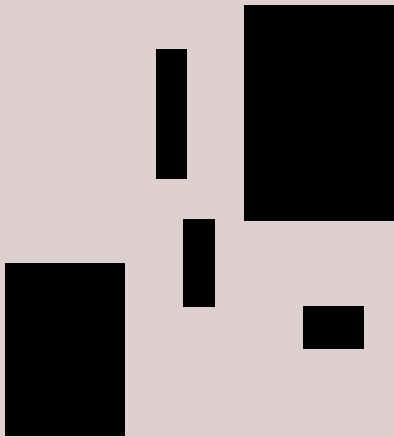


\*To maximize the success of rolling out a HSA plan, the State should consider implementation for a January 1 effective date, which has other timing considerations that are discussed in further detail later in this document.

## FY19 Planning



## Site-of-Care Steerage



# Considerations for the SEBC

## Site-of-care steerage

### Topic Refresher:

Members pay lower out-of-pocket costs for using the most appropriate place of service for the care they need.

- Both Aetna and Highmark administer site-of-care steerage for the State today for select services

Service	Current Provision (eff. 7/1/2016)	Utilization Results through March 2017*
Urgent Care	<ul style="list-style-type: none"><li>Urgent Care visit: \$15/\$20 copay (HMO/PPO)</li><li>Emergency room visit: \$150 copay</li></ul>	<ul style="list-style-type: none"><li>Visits to emergency rooms for urgent care treatable conditions declined by 1.4%</li><li>Utilization of urgent care facilities increased by 6.6%</li></ul>
High Tech Imaging	<ul style="list-style-type: none"><li>Outpatient facility, freestanding: \$0 copay</li><li>Outpatient facility, hospital-based: \$35 copay</li></ul>	<ul style="list-style-type: none"><li>Utilization of high tech radiology services declined by 3.1% in outpatient hospital facilities</li><li>Utilization of high tech radiology services increased by 5.6% in freestanding facilities</li></ul>

- Today, Aetna also utilizes a site-of-care steerage program with infusion therapy. For members utilizing high cost infusion therapy pharmaceuticals, there exists a mechanism for Aetna's clinical staff to steer members to an at-home infusion setting
  - This program is currently in place and is projected to yield over \$500k of plan savings in FY18
- Highmark is developing a site-of-care steerage program with infusion therapy that is similar to Aetna's, and there is potential for significant savings associated with this program which the State should continue to explore

\* Source: Truven FY 2017 3rd Quarter Utilization report. Based on most recent 12 months of incurred data (4/1/2016 – 3/31/2017) compared to prior 12 months incurred period (4/1/2015 – 3/31/2016). Copay differential implemented 7/1/2016 for the PPO and HMO plans.

# Considerations for the SEBC

## Revised design alternatives – Imaging and outpatient lab services

- The following plan design options were modeled by Aetna and Highmark for the Comprehensive PPO and HMO plans:

Service	Current	Preliminary Design 1 <sup>1</sup>	Design 2	Design 3	Design 4
<b>Basic Imaging</b> <ul style="list-style-type: none"> <li>Freestanding Facility</li> <li>Hospital-based Facility</li> </ul>	<ul style="list-style-type: none"> <li>\$20 copay</li> <li>\$20 copay</li> </ul>	<ul style="list-style-type: none"> <li>\$0 copay</li> <li>\$35 copay</li> </ul>	<ul style="list-style-type: none"> <li>\$10 copay</li> <li>\$45 copay</li> </ul>	<ul style="list-style-type: none"> <li>\$20 copay</li> <li>\$55 copay</li> </ul>	<ul style="list-style-type: none"> <li>\$25 copay</li> <li>\$60 copay</li> </ul>
<b>High Tech Imaging</b> <ul style="list-style-type: none"> <li>Freestanding Facility</li> <li>Hospital-based Facility</li> </ul>	<ul style="list-style-type: none"> <li>\$0 copay</li> <li>\$35 copay</li> </ul>	<ul style="list-style-type: none"> <li>\$0 copay</li> <li>\$50 copay</li> </ul>	<ul style="list-style-type: none"> <li>\$10 copay</li> <li>\$60 copay</li> </ul>	<ul style="list-style-type: none"> <li>\$20 copay</li> <li>\$70 copay</li> </ul>	<ul style="list-style-type: none"> <li>\$25 copay</li> <li>\$75 copay</li> </ul>
<b>Outpatient Lab</b> <ul style="list-style-type: none"> <li>Preferred Lab</li> <li>Other Lab</li> </ul>	<ul style="list-style-type: none"> <li>\$10 copay</li> <li>\$10 copay</li> </ul>	<ul style="list-style-type: none"> <li>\$10 copay</li> <li>\$20 copay</li> </ul>	<ul style="list-style-type: none"> <li>\$10 copay</li> <li>\$25 copay</li> </ul>	<ul style="list-style-type: none"> <li>\$10 copay</li> <li>\$30 copay</li> </ul>	<ul style="list-style-type: none"> <li>\$10 copay</li> <li>\$35 copay</li> </ul>

- For both Aetna and Highmark, freestanding facilities owned by hospitals (i.e., Christiana Care Health System Imaging Centers) are treated as outpatient hospital facilities
- If the GHIP were to implement site-of-care steerage for Basic Imaging Services through freestanding facilities, the number of imaging centers available to GHIP members in Delaware through the Aetna and Highmark respective networks would remain unchanged

<sup>1</sup> Preliminary design presented during 8/21 SEBC meeting

# Site-of-care steerage

## Estimated savings summary – best estimate

Carrier	Modeled Designs	Annual Claim Savings (%) <sup>2</sup>	Annual Claim Savings (\$)	Annual Claim Savings General Fund (\$)
Aetna	Preliminary Design 1 <sup>1</sup>	0.35%	\$0.5m	\$0.3m
Highmark		0.20%	\$0.8m	\$0.5m
Total Saving Opportunity – Design 1:			\$1.3m	\$0.8m
Aetna	Design 2	0.48%	\$0.7m	\$0.5m
Highmark		0.33%	\$1.3m	\$0.8m
Total Savings Opportunity – Design 2:			\$2.0m	\$1.3m
Aetna	Design 3	0.65%	\$1.0m	\$0.6m
Highmark		0.58%	\$2.2m	\$1.4m
Total Savings Opportunity – Design 3:			\$3.2m	\$2.0m
Aetna	Design 4	0.85%	\$1.3m	\$0.8m
Highmark		0.70%	\$2.7m	\$1.7m
Total Savings Opportunity – Design 4:			\$4.0m	\$2.5m

- The four design options modeled above assume design changes are adopted to promote site-of-care steerage for basic imaging services, high-tech imaging services and outpatient lab services
  - Consistent with existing site-of-care steerage design, modeling assumes that these changes would only apply to the Comprehensive PPO and the HMO plans
  - CDH Gold and First State Basic plans already have member cost differential built into design (via coinsurance for most plan provisions) to incentivize utilization of lower cost providers
- Member disruption will vary based on procedure, education and specific provider

General Fund split based on GHIP enrollment distribution by agency/department as of February 2017 as reported by Truven and FY17 premium levels  
Savings for active and pre-65 retiree populations only; based on each vendor's best estimate of the expected utilization at the desired site of care.

<sup>1</sup> Preliminary design presented during 8/21 SEBC meeting; rounding may cause some numbers to vary slightly from original document

<sup>2</sup> Savings largely attributable to copay differential rather than changes in member behavior

# Site-of-care steerage

## Estimated savings summary – maximum opportunity

Carrier	Modeled Designs	Annual Claim Savings (%)	Annual Claim Savings (\$)	Annual Claim Savings General Fund (\$)
Aetna <sup>1</sup>	Preliminary Design 1 <sup>3</sup>	0.89%	\$1.4m	\$0.9m
Highmark <sup>2</sup>		1.76%	\$6.8m	\$4.3m
Total Saving Opportunity – Design 1:			\$8.2m	\$5.2m
Aetna <sup>1</sup>	Design 2	1.20%	\$1.8m	\$1.2m
Highmark <sup>2</sup>		1.89%	\$7.3m	\$4.7m
Total Savings Opportunity – Design 2:			\$9.1m	\$5.9m
Aetna <sup>1</sup>	Design 3	1.52%	\$2.3m	\$1.5m
Highmark <sup>2</sup>		1.97%	\$7.6m	\$4.8m
Total Savings Opportunity – Design 3:			\$9.9m	\$6.3m
Aetna <sup>1</sup>	Design 4	1.74%	\$2.7m	\$1.7m
Highmark <sup>2</sup>		2.02%	\$7.8m	\$5.0m
Total Savings Opportunity – Design 4:			\$10.5m	\$6.7m

- For illustrative purposes only, the four design options modeled above reflect the maximum site-of-care steerage savings opportunity for basic and high-tech imaging and outpatient lab services
  - Intended to highlight the range of achievable savings based on more effective steerage through copay differential and behavior change
  - Reflects aggressive but achievable steerage assumptions: 50% of high-tech imaging claims and 75% of basic imaging claims will be incurred at a freestanding facility

General Fund split based on GHIP enrollment distribution by agency/department as of February 2017 as reported by Truven and FY17 premium levels

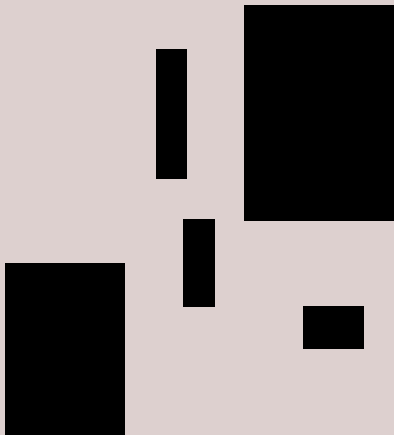
Savings for active and pre-65 retiree populations only

<sup>1</sup> Savings based on number of visits calculated using 7/1/2017 membership count; X-rays, ultrasounds and mammography are grouped under basic imaging, all other radiology services are grouped under high tech.

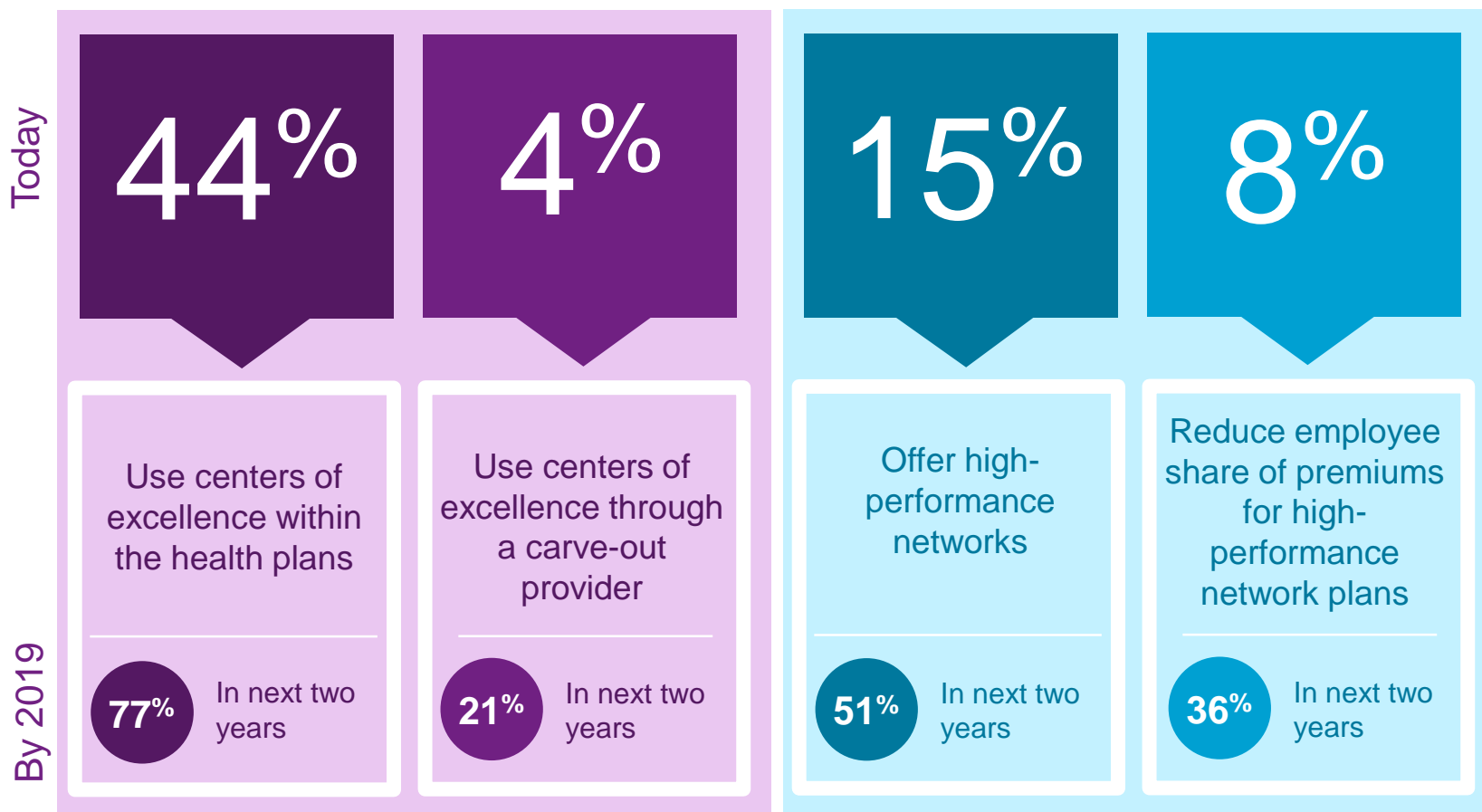
<sup>2</sup> Savings based on the number of unique members that had claims in these categories in the previous year

<sup>3</sup> Preliminary design presented during 8/21 SEBC meeting; rounding may cause some numbers to vary slightly from original document

## Centers of Excellence



## Use of centers of excellence (COEs) with the health plan could expand to more than three-quarters of companies by 2019



Sample: Companies with at least 1,000 employees.

Source: 2017 Willis Towers Watson Best Practices in Health Care Employer Survey.

## Centers of excellence

### Comparison of carve-in and carve-out approaches

- While Highmark and Aetna both offer COEs for a wide variety of procedures, there exist several carve-out vendors that can administer a COE network
- Three leaders in this space include: BridgeHealth, Carrum Health and SurgeryPlus
  - BridgeHealth: Network not currently built in the DE (and surrounding) marketplace
  - Carrum Health: Network primarily located in western United States
  - Surgery Plus (Employer's Direct): Network not currently built in the DE (and surrounding) marketplace

#### Comparison of Carve-in and Carve-out COE Approaches

	Medical Carriers	Carve-Out Vendors
COE Capabilities	More established in the COE marketplace than carve-out vendors and offer a wider range of procedures. Generally, COE is not available by specific procedure, but only by group of procedure categories (i.e., cardiac)	Offer more flexibility and robust concierge coordination support
COE Network	Focus on facility COE designations, but these may differ from other provider designations such as Aetna Aexcel and Highmark True Performance	Approaches to network development vary; some are facility-based and others are provider/surgeon-based  Would need to partner with medical TPAs to ensure that claims incurred with providers that meet quality and cost standards can be adjudicated at the in-network level, regardless of medical plan out-of-network status
Savings and ROI	Do not typically offer bundled pricing or ROI or savings transparency	Focus on bundled pricing / case rates. Some carve-out vendors have demonstrated greater willingness to tie savings and ROI to performance guarantees
Fees	Fee often embedded within core ASO fees, or nominal PEPM fee charged for steerage to COE network	Typically charge a fee (PEPM and/or a percentage of savings associated with the bundled case rates per surgery)

**SEBC should continue to monitor the marketplace for developments and consideration of future vendor exploration**

# Centers of excellence

## Considerations for the SEBC

### **Topic Refresher:**

*A Center of Excellence (COE) is a facility that has been identified as delivering high quality services and superior outcomes for specific procedures or conditions. COEs may incorporate separate contracting arrangements for a predetermined set of services (e.g., bundled payments). Plan design steerage to encourage use of COEs is optional.*

- Both Aetna and Highmark designate certain facilities within their provider networks as COEs
- Neither Aetna nor Highmark's COE network can be customized to exclude higher cost providers (this is due to contractual agreements between the TPA and providers)
- Aetna and Highmark COE network comments:
  - Both vendors are unable to designate out-of-network providers/facilities as COEs
  - For Highmark, the Blue Cross Blue Shield Association guidelines do not allow for the administration of customized plan design steerage to a COE for certain procedures but not others
    - All COE procedures are bundled; Highmark's system does not allow unbundling
    - Highmark's system only provides two options for COE benefit election, "Yes" to have all applicable procedure codes included or "No" to opt out
  - Aetna cannot customize COEs to steer members only to certain procedures
    - COEs are intended to be a broader offering in each specialty area (bariatric, cardiac and orthopedic) and systems are setup at COE level, not procedure level
    - Based on Aetna's experience, plan sponsors participate in COEs targeting the best savings resulting from steering towards multiple procedures

<sup>1</sup> Reimbursement available for patient and one companion and applies to all COEs (bariatric, cardiac and orthopedic)

# Centers of excellence

## Considerations for the SEBC

- In-network prior authorization currently in place and is performed by the provider
- Vendors do not consider requiring members to personally request prior authorization as a viable approach to educating members on the availability of COEs through customer service
  - Aetna unable to require members to call customer service for prior authorization, such approach is typical for out-of-network providers
  - Highmark indicated that if providers call promptly for prior authorization there may be opportunity for the health coach team to contact the patient prior to the procedure, however:
    - Success of the outreach would depend on the member picking up the call
    - Approach may be challenging as member and surgeon most likely have agreed on the facility in advance and changes may be frustrating for the member
- Vendor recommendations, based on BOB customer experience for member steerage towards COEs:
  - Aetna and Highmark agreed on implementing a benefit differential that favors COE use
  - Highmark emphasized the importance of executing an effective communication strategy

<sup>1</sup> Reimbursement available for patient and one companion and applies to all COEs (bariatric, cardiac and orthopedic)

# Centers of excellence

Available ✓  
Not Available ✗

## Comparison of COE-covered procedures by Aetna and Highmark

- Procedures available through Cardiac COEs

DRG #	Diagnostic Related Group (DRG)	Aetna	Highmark
215	Other heart assist system implant	✓	✗
216	Cardiac valve & other major cardiothoracic procedure w card cath w/ MCC	✓	✓
217	Cardiac valve & other major cardiothoracic procedure w card cath w/CC	✓	✗
218	Cardiac valve & other major cardiothoracic procedure w card cath w/o CC/MCC	✓	✓
219	Cardiac valve & other major cardiothoracic procedure w/o card cath w/ MCC	✓	✓
220	Cardiac valve and other major cardiothoracic procedure w/o card cath w/CC	✓	✓
221	Cardiac valve & other major cardiothoracic procedure w/o card cath w/o CC/MCC	✓	✓
222	Cardiac defibrillator implant w/ cardiac cath w/ AMI/HF/shock w/ MCC	✓	✗
223	Cardiac defibrillator implant w cardiac cath w AMI/HF/shock w/o MCC	✓	✗
224	Cardiac defibrillator implant w/ cardiac cath w/o AMI/HF/shock w/ MCC	✓	✗
225	Cardiac defibrillator implant w/ cardiac cath w/o AMI/HF/shock w/o MCC	✓	✗
226	Cardiac defibrillator implant w/o cardiac cath w/ MCC	✓	✗
227	Cardiac defibrillator implant w/o cardiac cath w/o MCC	✓	✗
228	Other cardiothoracic procedure w/ MCC	✓	✗
229	Other cardiothoracic procedure w/o MCC	✓	✗
231	Coronary bypass w/ PTCA w/ MCC	✓	✗
232	Coronary bypass w/ PTCA w/o MCC	✓	✓
233	Coronary bypass w/ cardiac cath w/ MCC	✓	✓
234	Coronary bypass w cardiac cath w/o MCC	✓	✓
235	Coronary bypass w/o cardiac cath w/ MCC	✓	✓
236	Coronary bypass w/o cardiac cath w/o MCC	✓	✓
237	Major cardiovascular procedures w/ MCC	✓	✗
238	Major cardiovascular procedures w/o MCC	✓	✗
242	Permanent cardiac pacemaker implant w/ MCC	✓	✗
243	Permanent cardiac pacemaker implant w/ CC	✓	✗
244	Permanent cardiac pacemaker implant w/o CC/MCC	✓	✗
245	AICD generator procedures	✓	✗

MCC: Major Complication or Comorbidity; CC: Complication or Comorbidity

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<sup>1</sup> Reimbursement available for patient and one companion and applies to all COEs (bariatric, cardiac and orthopedic)

## Centers of excellence

### Comparison of COE-covered procedures by Aetna and Highmark

- Procedures available through Cardiac COEs (*continued*)

DRG #	Diagnostic Related Group (DRG)	Aetna	Highmark
246	Perc cardiovascular procedure w/ drug-eluting stent w/ MCC	✓	✓
247	Perc cardiovascular procedure w drug-eluting stent w/o MCC	✓	✓
248	Perc cardiovascular procedure w/ non-drug eluting stent w/ MCC	✓	✓
249	Perc cardiovascular procedure w non-drug-eluting stent w/o MCC	✓	✗
250	Perc cardiovascular procedure w/o coronary artery stent w/ MCC	✓	✓
251	Perc cardiovascular procedure w/o coronary artery stent w/o MCC	✓	✓
258	Cardiac pacemaker device replacement w/ MCC	✓	✗
259	Cardiac pacemaker device replacement w/o MCC	✓	✗
268	Aortic and heart assistance procedure except pulsation balloon w/ MCC	✓	✗
269	Aortic and heart assistance procedure except pulsation balloon w/o MCC	✓	✗
270	Other major cardiovascular procedures w/ MCC	✓	✗
271	Other major cardiovascular procedures w/CC	✓	✗
272	Other major cardiovascular procedures w/o CC/MCC	✓	✗
273	Percutaneous intracardiac procedures w/ MCC	✓	✗
274	Percutaneous intracardiac procedures w/o MCC	✓	✗
308	Cardiac arrhythmia & conduction disorders w/ MCC	✓	✗
309	Cardiac arrhythmia & conduction disorders w/CC	✓	✗
310	Cardiac arrhythmia & conduction disorders w/o CC/MCC	✓	✗
981	Extensive O.R. procedure unrelated to principal diagnosis	✗	✓

MCC: Major Complication or Comorbidity; CC: Complication or Comorbidity

## Centers of excellence

### Comparison of COE-covered procedures by Aetna and Highmark

- Procedures available through Orthopedic and Spine COEs

DRG #	Diagnostic Related Group (DRG)	Aetna	Highmark
<b>Orthopedic</b>			
461	Bilateral or multi major joint procedures of lower extremity w/ MCC	✓	✗
462	Bilateral or multi major joint procedures of lower extremity w/o MCC	✓	✓
464	Wound debridement and skin graft except hand, for musculoskeletal and connective tissue disorders w/ CC	✗	✓
466	Revision of hip or knee replacement w/ MCC	✓	✗
467	Revision of hip or knee replacement w/ CC	✓	✓
468	Revision of hip or knee replacement w/o CC/ MCC	✓	✓
469	Major joint replacement w/ MCC	✓	✓
470	Major joint replacement w/o MCC	✓	✓
<b>Spine</b>			
28	Spinal procedure w/ MCC	✗	✓
29	Spinal procedure w/ CC or spinal neurostimulator	✗	✓
30	Spinal procedure w/o CC/MCC	✗	✓
453	Combined anterior/posterior spinal fusion w/ MCC	✓	✓
454	Combined anterior/posterior spinal fusion w/ CC	✓	✓
455	Combined anterior/posterior spinal fusion w/o CC/MCC	✓	✓
456	Spinal fusion except cervical w/ spinal curv/ infection/ malign or 9+ fusion w/ MCC	✓	✓
457	Spinal fusion except cervical w/ spinal curv/ infection/ malign or 9+ fusion w/ CC	✓	✓
458	Spinal fusion except cervical w/ spinal curv/ infection/ malign or 9+ fusion w/o CC MCC	✓	✓
459	Spinal fusion except cervical w/ MCC	✓	✓
460	Spinal fusion except cervical w/o MCC	✓	✓
471	Cervical spinal fusion w/ MCC	✓	✓
472	Cervical spinal fusion w/o CC	✓	✓
473	Cervical spinal fusion w/o MCC	✓	✓
519	Back and neck procedures, except spinal fusion w/ CC	✗	✓
520	Back and neck procedures, except spinal fusion w/o CC/MCC	✗	✓
957	Multiple significant trauma	✗	✓

MCC: Major Complication or Comorbidity; CC: Complication or Comorbidity

## Centers of excellence

Historical view of COE utilization for GHIP members (*Highmark*)<sup>1</sup>

Type of COE	Procedure	Total number of procedures (All facility types)	Total performed at COE facilities	Total performed at In-network non-COE facilities	Total performed at out-of-network facilities
Cardiac	Cardiac Valve	33	24	9	-
	Coronary Bypass	43	39	4	-
	Procedures with Coronary Artery Stent	100	87	13	-
	Extensive O.R. Procedure Unrelated to Principal Diagnosis	1	1	-	-
Orthopedic	Major Joint Procedures	23	9	14	-
	Revision of Hip or Knee Replacement	27	10	17	-
	Major Joint Replacement	632	137	495	-
Spine	Spine Surgery	11	8	3	-
	Spinal Fusion	143	111	32	-
	Multiple Significant Trauma	1	1	-	-
	Other Spinal Procedures	6	5	1	-

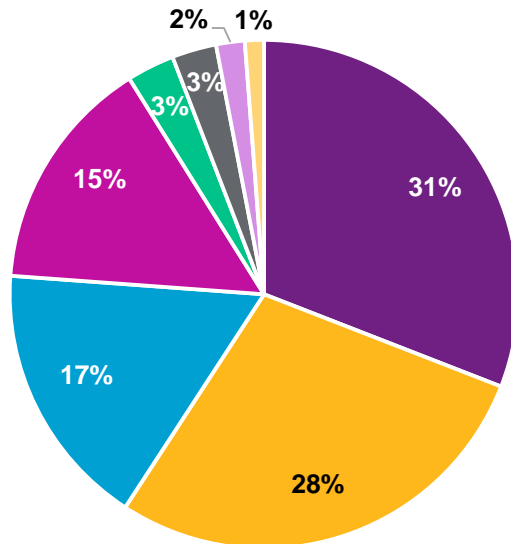
- Chart above reflects 24 months of GHIP experience for all cardiac, knee/hip and spinal procedures accessible through Highmark COEs
- All cardiac, orthopedic and spine procedures were performed at in-network COE and non-COE facilities
  - 58% of procedures were performed at non-COE facilities, driven by major joint replacement
  - The majority of major joint replacements were done in an in-network non-COE facility

<sup>1</sup> Claims period 08/01/2015 - 07/31/2017

## Centers of excellence

### Historical view of COE utilization for GHIP members (*Highmark*)

- 632 major joint replacements reported by Highmark from 8/1/2015 to 7/31/2017, 137 performed at COE facilities and 495 at in-network non-COE facilities
- The chart below details the procedures, categorized as major joint replacements, performed at in-network non-COE facilities (91% of total)
  - 59% (293) right or left knee joint replacements
  - 32% (158) right or left hip joint replacements



Orthopedic COE – Major Joint Replacement	
Procedures	Total number of procedures performed at in-network non-COE facilities
Right knee joint replacement	153
Left knee joint replacement	140
Right hip joint replacement	84
Left hip joint replacement	74
Total knee replacement	15
Other <sup>1</sup>	14
Percutaneous anesthetic into peripheral nerves and plexi	9
Total hip replacement	6
<b>Total Major Joint Replacement Procedures</b>	<b>495</b>

<sup>1</sup> "Other" category includes procedures performed less than three times during the 24-month period evaluated. Left hip joint, femoral surface replacement (3), left knee joint femoral surface replacement (3) therapeutic musculoskeletal exercise treatment (3); right knee joint tibial surface replacement (2), left knee joint tibial surface replacement (1), partial hip replacement (1) and right hip joint acetabular surface replacement (1)

## Centers of excellence

### Historical view of COE utilization for GHIP members (*Aetna*)<sup>1</sup>

Type of COE	Procedure	Total number of procedures (All facility types)	Total performed at COE facilities	Total performed at In-network non-COE facilities	Total performed at out-of-network facilities
Cardiac	Interventional <sup>2</sup>	2	-	2	-
	Rhythm	5	5	-	-
	Surgery	1	-	1	-
Orthopedic/ Spine	Total Joint Replacement	19	8	11	-
	Spine	17	15	2	-

- Chart above reflects 24 months of GHIP experience for all cardiac, knee/hip and spinal procedures accessible through Aetna COEs
- All cardiac, orthopedic and spine procedures were performed at in-network COE and non-COE facilities
  - All cardiac/rhythm procedures and most spine procedures were delivered at COE facilities
  - The majority of total joint replacements were done in an in-network non-COE facility

<sup>1</sup> Claim period 07/01/2014 - 06/30/2016

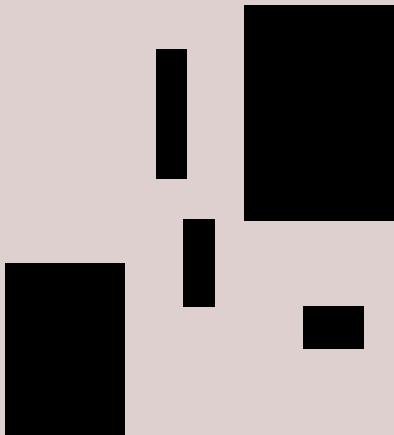
<sup>2</sup> Catheter based treatment of structural heart diseases

# Centers of excellence

## Recommended approach

- While the third party vendor marketplace continues to evolve, there exists an opportunity to move forward with a limited COE penetration with the GHIP's current vendor partners
  - The GHIP should continue to monitor the viability of the third-party COE vendor landscape, as future opportunities may exist
- The recommendation for FY19 would be to adopt the Orthopedic and Spine COEs for both Highmark and Aetna
  - Aetna's spine COE is embedded within their Orthopedic COE while Highmark Orthopedic and Spine COEs are separate
  - Offers a level of consistency in steerable conditions between both carriers
  - Drives members to the highest quality facilities, improving outcomes and reducing cost
  - Clear expectations will need to be set with both Aetna and Highmark to ensure protocol is in place to appropriately steer members and administer the program according to the GHIP's intention
- Design approach:
  - Similar to the steerage encouraged by the bariatric and transplant plan design, the recommendation is to utilize a consistent benefit differential
    - COE Facility: Covered at current in-network benefit level (*no change from current design*)
    - Non COE Facility: Covered at 75% (after applicable copay/deductible)
- Cost Savings:
  - Moving forward with adopting the **orthopedic and spine COEs** for both Aetna and Highmark would yield approximately \$3.4m of annual savings

## Reference-Based Pricing



# Reference-based pricing

## Considerations for the SEBC

### Topic Refresher:

*Plan sponsors pay a fixed amount or "reference" price toward the cost of a specific health care service, and health plan members must pay the difference in price if they select a more costly health care provider or service.*

- Both Aetna and Highmark have capabilities to administer reference-based pricing (RBP)
- Program works best with coinsurance based plan designs (vast majority of the State's members are enrolled in the PPO and HMO plans, which are copay-based)
  - Members in a copay-based program are not currently exposed to differentials in underlying cost and would require intensive member education to move to reference-based pricing model
  - In a copay-based model, all billing occurs at point-of-care, while in coinsurance and reference-based models, members may receive a bill after the claim has been adjudicated
- Reference-based pricing differs slightly between Aetna and Highmark in terms of covered procedures, and network breadth (some network contracts stipulate provider may balance bill up to the contracted allowance, while others do not)
- Aetna and Highmark have limited data/analysis to conclude whether or not changes in member utilization patterns have occurred as a result of reference-based pricing being implemented
- In order for a reference-based pricing program to be successful, an intensive communication and member education program would need to be rolled out

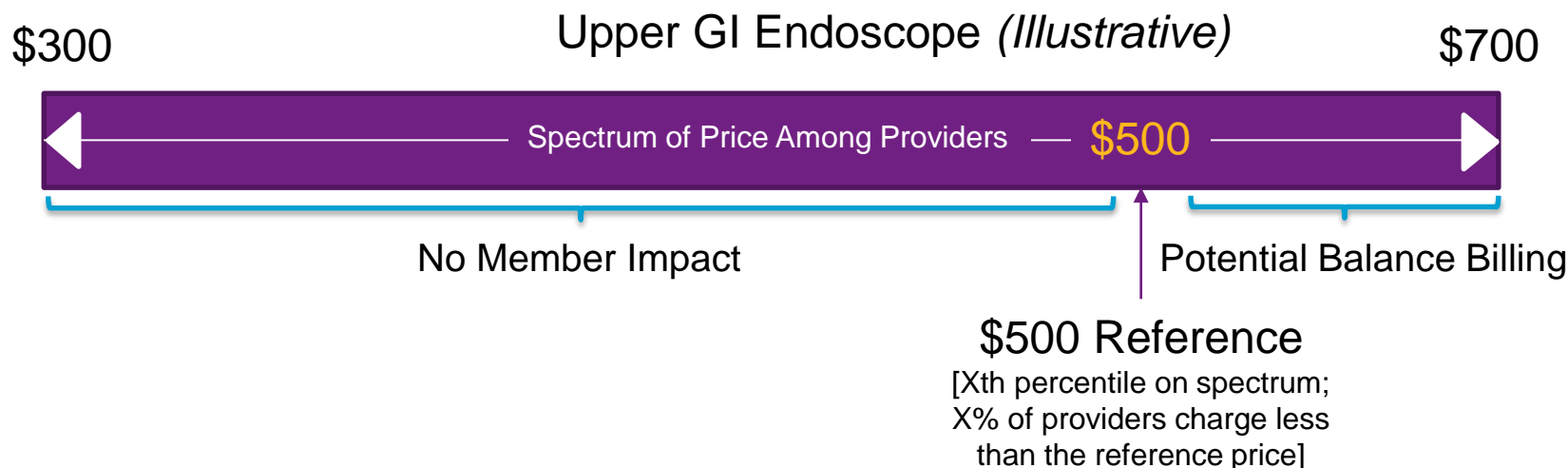
Vendor	Procedures Available <sup>1</sup>	Customers with RBP <sup>2</sup>	Program Administration Cost	Additional Considerations
Aetna	6 Outpatient procedures 4 Outpatient imaging	6	None	Uses RBP bundles to group procedures
Highmark	21 Outpatient procedures 7 Outpatient imaging	1	\$0.50 PCPM	6 month roll-out required

<sup>1</sup> Full list available in appendix of materials presented during the 8/21/17 SEBC meeting.

<sup>2</sup> For Aetna and Highmark customers that have RBP in place today, a limited amount membership currently utilizes providers in Delaware (200 members for Aetna, none for Highmark).

# Reference-based pricing

## Mechanics of setting the reference price



- Reference price set at percentile of all provider charges
- The plan sponsor may set the reference price, in conjunction with the vendor partner, based on a sliding scale that has a correlation between savings and member impact
  - Higher percentile – less savings, less member impact
  - Lower percentile – more savings, more member impact
- The bulk of FY18 savings are generated by member cost shifting, and may also drive utilization to lower cost providers

# Reference-based pricing

## Estimated savings summary

Carrier	Annual Claim Savings (%)	Annual Claim Savings (\$)	Annual Claim Savings General Fund (\$)
Aetna	1.31%	\$2.0m	\$1.3m
Highmark	0.23%	\$0.9m	\$0.6m

**Total Annual Savings Opportunity, General Fund: \$1.9m**

- Modeling above assumes ALL procedures available for reference-based pricing are adopted
- Above modeling assumes Aetna reference set between 25<sup>th</sup> and 100<sup>th</sup> percentile (varies by procedure), and assumes Highmark reference set at 90<sup>th</sup> percentile
- Member disruption will vary based on procedure, education and specific provider utilized
  - Highmark cited that the potential average member liability can vary between \$40 - \$600 for outpatient imaging and \$600 - \$3,000 for outpatient procedures. Approximately 14% of outpatient imaging claims and 8% of outpatient procedure claims exceed the reference price
  - Aetna cited that for their available reference procedures, approximately 43% of the modeled claims exceed the reference price

### Highmark notes:

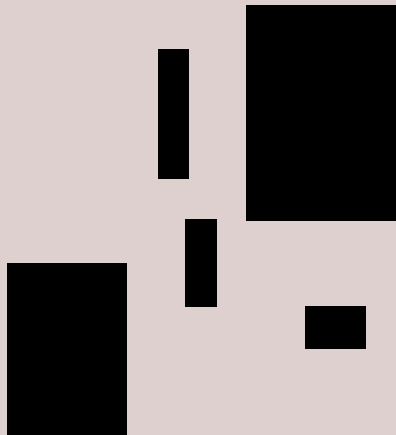
Estimate provided by Highmark on 8/9/2017 based upon RBP modeling provided to the State of Delaware on March 7, 2016: Reference-Based Pricing overview presentation. 90% reference percentile utilized for modeling. The reference cost represents a percent of providers rendering the service at a cost at/or below a stipulated dollar level. Savings for active and pre-65 retiree populations only. Savings noted above are net of \$0.50 PCPM program fees

### Aetna notes:

Estimates provided by Aetna on 8/15/2017. Aetna's reference price is set between the 25<sup>th</sup> and 100<sup>th</sup> percentile (varies by procedure) of allowed rates for the highest cost service that is frequently billed (i.e. represents at least 10% of the volume for that procedure group). The reference price is determined for each geographic area and procedure group based on member access. Savings for active and pre-65 retiree populations only.

General Fund split based on GHIP enrollment distribution by agency/department as of February 2017 as reported by Truven and FY17 premium levels

## Cost Transparency Tools



# Cost transparency tools

## Consumer continuum of transparency solutions

### Topic Refresher:

Describes tools that provide members with additional visibility into the total cost of health care services that they may incur.

- May be used to estimate the total cost for a medical procedure, a prescription or the total annual amount spent on health care by an employee (i.e., payroll contributions and member out-of-pocket costs)
- Often include provider quality ratings too



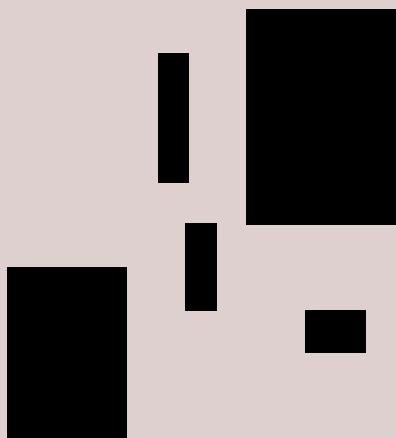
# Cost transparency tools

## Comparison of carve-in and carved-out tools

- The market for transparency has rapidly developed over the past few years, with many different vendors and carriers entering the space
- While Highmark and Aetna both offer cost transparency tools for a wide variety of procedures, there exist several carve-out vendors that have similar capabilities
- Two leaders in this space include: **Castlight** and **Healthcare Bluebook**

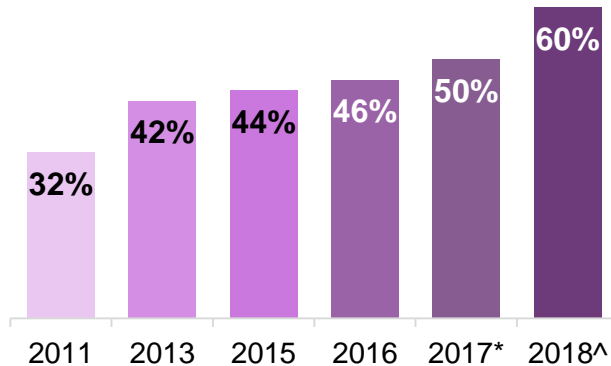
	Medical Carriers	Carve-Out Vendors
Data sources	Usually limited to third party vendor's own provider network, which can affect availability of data for certain procedures	Usually broader in scope and based on a national data set
Data integration	Most up-to-date data about providers' network participation	May not contain real-time information on provider participation in specific TPA networks
Member experience	Usually embedded on vendor's member portal, but may be difficult to locate	Consistent member experience regardless of medical plan option selected
Vendor pricing	Cost for transparency tool usually carved into vendor's fees	Access to transparency tool comes at an additional cost

## Tobacco Surcharge



# Tobacco surcharge

## Percent of employers with a tobacco surcharge



Note: \* Planned in 2017, ^ Considering in 2018.

Years 2011, 2013, and 2015 are based on prior years of the TW Staying@Work Survey

Sample: Companies with at least 1,000 employees.

Source: 2016 Willis Towers Watson Best Practices in Health Care Employer Survey.

# \$600

Median annual tobacco surcharge  
amount for medical coverage

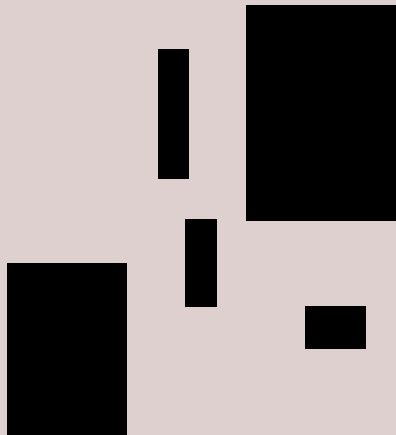
- In general, employers with tobacco surcharges tend to see 5% - 15% of enrolled employees self-identify as tobacco users
- Implementing a tobacco surcharge is best managed in an active enrollment process (prevalent market practice)
- If the State chose to **implement a tobacco surcharge<sup>1</sup>** for active employees and pre-65 retirees who self-identify as having used tobacco within the last 12 months, the range of potential savings would be as follows:

% of enrolled employees/pre-65 retirees who self-report as tobacco users	Net Savings from Annual Surcharge			
	\$150	\$300	\$450	\$600
5%	\$332,000	\$665,000	\$997,000	\$1,329,000
10%	\$665,000	\$1,329,000	\$1,994,000	\$2,658,000
15%	\$997,000	\$1,993,000	\$2,990,000	\$3,986,000
20%	\$1,329,000	\$2,658,000	\$3,987,000	\$5,315,000

<sup>1</sup> Would most likely require legislative change to implement as this would change employee cost share.

Based on active/pre-65 employee enrollment as of June 30, 2017 (44,295 enrolled employees/pre-65 retirees).

## HSA Plan Option



# HSA plan considerations

- Eighty-six percent (86%) of employers<sup>1</sup> offer or are planning to offer an account based health plan, i.e., either an HRA or HSA plan, by 2018
  - Seventy-three percent (73%) offer an HSA plan in 2017, with another 7% planning to offer by 2018
- The addition of a new health plan with Health Savings Accounts (HSA) would promote shared responsibility for impact of members' health care decisions
- Impact of this plan option is highly dependent on enrollment and member engagement

## Enrollment drivers – examples

- Offering this plan at no/very low cost to employees
- Freezing enrollment in other medical plans<sup>2</sup>
- Offering this plan as the only option for employees hired on or after a certain date<sup>2</sup>

## Engagement drivers – examples

- Offering cost transparency tools
- Seeding the HSA at the beginning of the plan year with employer-provided funding
- Offering additional employer HSA contributions as an incentive for participating in desired health behaviors (i.e., getting an annual physical)

- To maximize the success of rolling out this type of plan, consider a January 1 effective date
  - Due to the tax benefits associated with the HSA
  - For optimal member experience, consider aligning the benefits plan year for all other benefits to the HSA plan year (i.e., from July 1 to January 1)
    - Would provide a more integrated, seamless experience
    - Broader implications of this change are outlined in the appendix

## HSA plan design and impact – *illustrative*

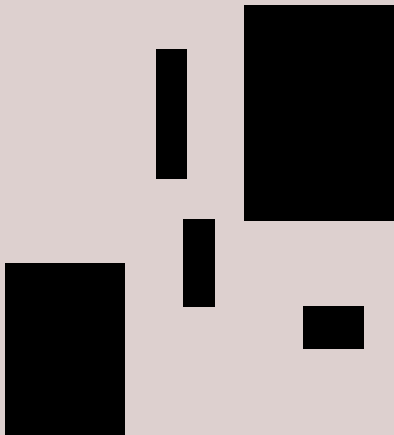
Plan Design (In-network)	HDHP/HSA
Deductible (Ind./Fam.)	\$2,000 / \$4,000
Account Funding (Ind./Fam.)	\$1,000 / \$2,000
Coinsurance	80%
Out-of-Pocket Max (Ind./Fam.)	\$4,500 / \$9,000
PCP Office Visit	80%
Specialist Office Visit	80%
Emergency Room	80%
Inpatient Care	80%
<b>Prescription Drug<sup>1</sup></b>	
Out-of-Pocket Max (Ind./Fam.)	Combined with medical
▪ Retail	\$8/\$28/\$50 after deductible
▪ Mail Order	\$16/\$56/\$100 after deductible
<b>Relative Benefit Value (RBV)<sup>2</sup></b>	<b>0.88</b>

- The IRS mandates certain plan design provisions to maintain tax-favored status of the HSA
  - Calendar year 2018 limits (ind./fam.)
    - Deductible: \$1,350 / \$2,700
    - Out-of-Pocket Max: \$6,650 / \$13,300
    - HSA contribution (combined employer and employee) : \$3,450 / \$6,900

<sup>1</sup> Retail 30 day supply; mail order 90 day supply

<sup>2</sup> RBV estimate includes HSA seed (seed dollars are \$1,000 Individual/\$2,000 Family)

## Plan Design and Cost Sharing



## Active/Pre-65 retiree combination design/cost sharing scenarios

- The following table illustrates annual State and General Fund savings associated with the following alternatives:
  - Add deductibles to the HMO and PPO plans, and
  - Increase the overall active/pre-65 retiree cost share by 1%, 2% and 3%

Deductible (single/family)	Current (10.6% Cost Share)		1% Increase (11.6% Cost Share)		2% Increase (12.6% Cost Share)		3% Increase (13.6% Cost Share)	
	State Total	General Fund <sup>1</sup>	State Total	General Fund <sup>1</sup>	State Total	General Fund <sup>1</sup>	State Total	General Fund <sup>1</sup>
Current Plan Design	\$0.0 M	\$0.0 M	\$6.7 M	\$4.3 M	\$13.4 M	\$8.6 M	\$20.1 M	\$12.9 M
\$50 / \$100	\$2.3 M	\$1.5 M	\$8.8 M	\$5.6 M	\$15.5 M	\$9.9 M	\$22.1 M	\$14.2 M
\$100 / \$200	\$4.3 M	\$2.8 M	\$10.5 M	\$6.8 M	\$17.2 M	\$11.1 M	\$23.9 M	\$15.3 M
\$150 / \$300	\$6.4 M	\$4.1 M	\$12.4 M	\$8.0 M	\$19.0 M	\$12.2 M	\$25.7 M	\$16.5 M
\$200 / \$400	\$8.7 M	\$5.6 M	\$14.4 M	\$9.3 M	\$21.1 M	\$13.5 M	\$27.7 M	\$17.8 M
\$250 / \$500	\$10.4 M	\$6.7 M	\$16.0 M	\$10.3 M	\$22.6 M	\$14.5 M	\$29.2 M	\$18.8 M
\$500 / \$1000	\$18.5 M	\$11.9 M	\$23.2 M	\$14.9 M	\$29.7 M	\$19.1 M	\$36.3 M	\$23.3 M

- Note: savings from adding deductibles are partially offset by a reduction in premium revenue since employee/pensioner contributions are a percentage of plan premium
- Based on expected FY18 active/pre-65 retiree premium cost share of 10.6%<sup>2</sup>; increases shown above move cost sharing in the direction towards market norms

<sup>1</sup> Splits calculated using GHIP group percentages based on Truven census and actual Fiscal Year 2016 Premium Contributions and Revenue as reported by OMB Financial Operations/PHRST

<sup>2</sup> Based on expected enrollment used to develop FY18 budget; reflects final TPA RFP decisions and anticipated migration

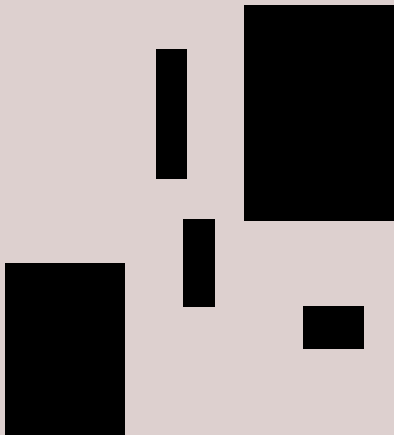
## Active/Pre-65 retiree design/cost sharing scenarios – employee impact

- The table below illustrates FY18 employee/pensioner annual contribution as a percent of pay, based on current contribution levels and for each the plan design and cost sharing alternatives under consideration
  - Illustrated for sample employees earning \$25,000 and \$50,000 annually

Annual Payroll Contribution as % of Pay <sup>1</sup>	Employee earning \$25,000 annually				Employee earning \$50,000 annually			
	Status Quo	Cost Share Increase			Status Quo	Cost Share Increase		
		+1%	+2%	+3%		+1%	+2%	+3%
HMO - Employee Only								
Current Plan Design	2.3%	2.5%	2.7%	2.9%	1.1%	1.2%	1.3%	1.5%
\$50 Deductible	2.3%	2.5%	2.7%	2.9%	1.1%	1.2%	1.3%	1.5%
\$500 Deductible	2.2%	2.4%	2.7%	2.9%	1.1%	1.2%	1.3%	1.4%
HMO - Family								
Current Plan Design	6.0%	6.5%	7.1%	7.6%	3.0%	3.3%	3.5%	3.8%
\$50 Deductible	5.9%	6.5%	7.1%	7.6%	3.0%	3.3%	3.5%	3.8%
\$500 Deductible	5.9%	6.4%	7.0%	7.5%	2.9%	3.2%	3.5%	3.8%
PPO - Employee Only								
Current Plan Design	5.0%	5.5%	6.0%	6.5%	2.5%	2.8%	3.0%	3.2%
\$50 Deductible	5.0%	5.5%	6.0%	6.5%	2.5%	2.8%	3.0%	3.2%
\$500 Deductible	5.0%	5.5%	5.9%	6.4%	2.5%	2.7%	3.0%	3.2%
PPO - Family								
Current Plan Design	13.1%	14.3%	15.6%	16.8%	6.5%	7.2%	7.8%	8.4%
\$50 Deductible	13.1%	14.3%	15.5%	16.8%	6.5%	7.2%	7.8%	8.4%
\$500 Deductible	12.9%	14.2%	15.4%	16.6%	6.5%	7.1%	7.7%	8.3%

<sup>1</sup> Reflects payroll contribution only; does not reflect out-of-pocket expense.

## Active Enrollment



# Active enrollment

## Considerations for the SEBC

- “Active enrollment” refers to the requirement for benefits-eligible employees to make an enrollment election (including waiving coverage) regardless of whether they are changing medical plans
- Major points of consideration associated with an active enrollment:
  1. Which employee/retiree groups would be subject to an active enrollment?
    - i. Active employees
    - ii. Non-Medicare retirees
    - iii. Medicare retirees
  2. What does an employee need to do in order to actively enroll?
    - i. Simply check off which plan they want to enroll in (or waive coverage)
    - ii. Option (i.) plus update their contact information
    - iii. Option (ii.) plus certify whether they and their enrolled dependents are tobacco users
  3. What happens if an employee doesn’t participate? (i.e., the “default” option)
    - i. No coverage (requires the most employee education; potentially the most disruptive<sup>1</sup>)
    - ii. Default into current election if already covered under medical plan, or no coverage if new hire (least disruptive, but requires no engagement from employees)
    - iii. Enrollment in the First State Basic plan (requires more consumer engagement than the State’s other plan options offered today; monthly employee contributions would decrease<sup>2</sup> by \$8 – \$77 for Employee Only coverage and by \$23 – \$201 for Family coverage)
    - iv. Enrollment in an HSA plan option (not for 7/1/18 – future state option if the State decides to implement an HSA plan)

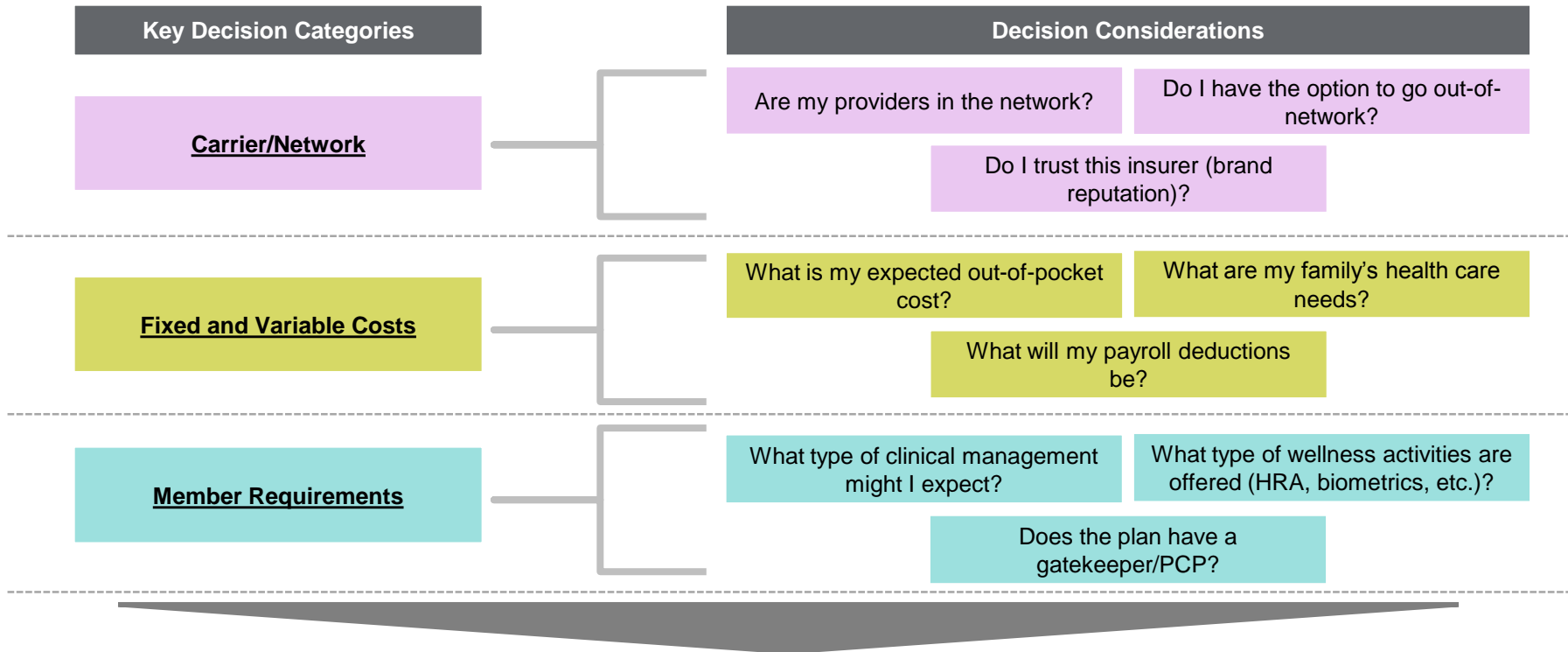
<sup>1</sup> Based on a comparison of FY18 employee contributions for the First State Basic plan relative to the CDH Gold, HMO and PPO plans.

<sup>2</sup> Potential implications of this option, including its affect on the GHIP meeting employer affordability guidelines under the ACA, should be discussed with the State’s legal counsel.

# Active enrollment

## Considerations for GHIP members

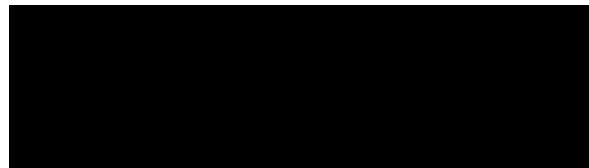
- At the point of enrollment, GHIP members have an opportunity to select a plan that best aligns with their current life situation



The open enrollment period is the time during which these key decision categories will be relayed to the member with an **Active Enrollment being an effective way of engaging members**

**A robust decision support tool will guide members** through a series of customized and personalized questions to help steer them to the best suited plan

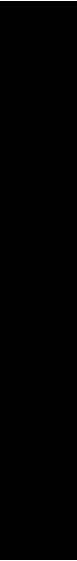
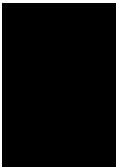
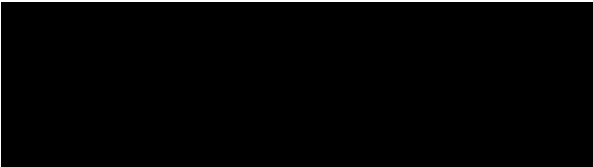
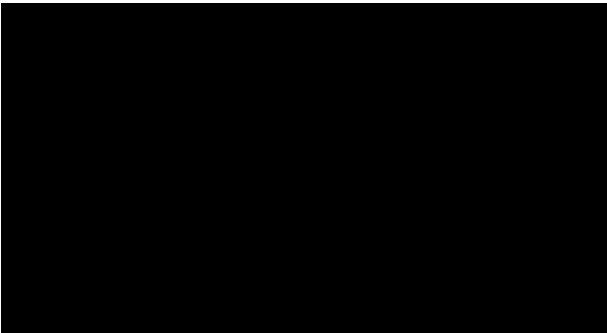
## Next Steps



## Next steps

- Items to discuss at upcoming SEBC meetings for FY19 and beyond:
  - Continued discussion of short-term opportunities for FY19
  - Spousal Coordination of Benefits Policy changes
  - Group Health Eligibility and Enrollment Rule changes
  - Employer-sponsored clinic follow up
  - Active enrollment
  - Possibility of modification to the plan year to align with calendar year (i.e., 7/1 to 1/1)

# Appendix



# Confines of the GHIP strategic development process

## Tactics requiring legislative changes

Potential tactic to address strategy	Illustrative example(s)	Requires legislative change?
Traditional plan design changes	Increase deductible by \$100	No
Non-traditional plan design changes	Implement reference-based pricing Add a third coverage tier for a narrow network	No
Adding a new medical plan	Adding CDHP/HSA or adding a PPO option that has a narrow network	No*
Removing a plan option specified by the Delaware Code	Removing the First State Basic plan	Yes**
Freezing enrollment in a medical plan	1. Freeze to new entrants 2. Freeze to new hires	Yes
Adding a vendor	Wellness vendor or engagement vendor	No
Adjustments in employee cost share	Increasing the payroll contribution for an employee from 12% to 15%	Yes
Adjustments in dependent cost share	Increasing the dependent cost sharing by 10%	Yes
Addition of surcharges	1. Add a tobacco and/or spousal surcharge 2. Wellness “dis-incentive” for non-participation	Yes
Addition of an incentive program	Paying an employee \$100 to get their biometric screening from their PCP	No
Implement a medical or Rx utilization management program	1. Implement high cost radiology management program 2. Discontinue coverage of certain high cost specialty drugs and/or compound drugs	No

\*Procurement would be involved in reviewing any amendments to vendor contracts for the new plan(s). Additionally, cost share would have to fit within one of the existing plans to avoid legislative change.

\*\*May require legal input regarding Delaware Code.

# Aetna/Highmark site-of-care steerage

## Estimated savings summary – Preliminary Design (Design 1)<sup>1</sup>

Type of service	Current (Aetna HMO/ Comprehensive PPO In-network)	Preliminary Proposed Design 1	Aetna HMO Annual Claim Savings <sup>2</sup>		Total Savings Opportunity	Highmark Comprehensive PPO (In-network design) Annual Claim Savings <sup>2</sup>		Total Savings Opportunity
			(%)	(\$)		(%)	(\$)	
Basic imaging services (e.g., X-rays, ultrasounds)	<ul style="list-style-type: none"> <li>Outpatient facility: \$20 copay</li> </ul>	<ul style="list-style-type: none"> <li>Outpatient facility, freestanding: \$0 copay</li> <li>Outpatient facility, hospital-based: \$35 copay</li> </ul>	0.05%	\$0.1m	<b>\$0.5m</b> (\$0.3m general fund)	0.10%	\$0.4m	<b>\$0.8m</b> (\$0.5m general fund)
High tech imaging services (e.g., MRI, CT scans)	<ul style="list-style-type: none"> <li>Outpatient facility, freestanding: \$0 copay</li> <li>Outpatient facility, hospital-based: \$35 copay</li> </ul>	<ul style="list-style-type: none"> <li>Outpatient facility, freestanding: \$0 copay</li> <li>Outpatient facility, hospital-based: \$50 copay</li> </ul>	0.05% <sup>3</sup>	\$0.1m		0.05%	\$0.2m	
Outpatient lab services	<ul style="list-style-type: none"> <li>Any lab: \$10 copay</li> </ul>	<ul style="list-style-type: none"> <li>Preferred lab (Quest/LabCorp): \$10 copay</li> <li>All other labs: \$20 copay</li> </ul>	0.20%	\$0.3m		0.05%	\$0.2m	

### Combined Aetna/Highmark Total Annual Savings Opportunity – Preliminary Design 1: **\$1.3m**

- Savings estimates assume that these changes are applicable only to Aetna HMO plan and Highmark Comprehensive PPO plan in-network design provisions
- While high tech imaging site-of-care steerage is already in place with the GHIP, the above proposal furthers the copay spread between freestanding and hospital-based outpatient facilities to differentiate between basic imaging and high tech imaging

<sup>1</sup> Preliminary design presented during 8/21 SEBC meeting.

<sup>2</sup> Savings estimates based on assumed utilization; estimates provided on 9/6/2017. Savings for active and pre-65 retiree populations only.

<sup>3</sup> Aetna commented that high tech imaging services yield <0.1% claims savings. 0.05% savings assumed.

# Aetna/Highmark site-of-care steerage

## Estimated savings summary – Design 2

Type of service	Current (Aetna HMO/ Comprehensive PPO In-network)	Proposed Design 2	Aetna HMO Annual Claim Savings <sup>1</sup>		Total Savings Opportunity	Highmark Comprehensive PPO (In-network design) Annual Claim Savings <sup>1</sup>		Total Savings Opportunity
			(%)	(\$)		(%)	(\$)	
Basic imaging services (e.g., X-rays, ultrasounds)	<ul style="list-style-type: none"> <li>Outpatient facility: \$20 copay</li> </ul>	<ul style="list-style-type: none"> <li>Outpatient facility, freestanding: \$10 copay</li> <li>Outpatient facility, hospital-based: \$45 copay</li> </ul>	0.15%	\$0.3m	<b>\$0.7m</b> (\$0.5m general fund)	0.24%	\$0.9m	<b>\$1.3m</b> (\$0.8m general fund)
High tech imaging services (e.g., MRI, CT scans)	<ul style="list-style-type: none"> <li>Outpatient facility, freestanding: \$0 copay</li> <li>Outpatient facility, hospital-based: \$35 copay</li> </ul>	<ul style="list-style-type: none"> <li>Outpatient facility, freestanding: \$10 copay</li> <li>Outpatient facility, hospital-based: \$60 copay</li> </ul>	0.08% <sup>2</sup>	\$0.1m		0.03%	\$0.1m	
Outpatient lab services	<ul style="list-style-type: none"> <li>Any lab: \$10 copay</li> </ul>	<ul style="list-style-type: none"> <li>Preferred lab (Quest/LabCorp): \$10 copay</li> <li>All other labs: \$25 copay</li> </ul>	0.25% <sup>3</sup>	\$0.3m		0.06% <sup>3</sup>	\$0.3m	

### Combined Aetna/Highmark Total Annual Savings Opportunity – Design 2: **\$2.0m**

- Savings estimates assume that these changes are applicable only to Aetna HMO plan and Highmark Comprehensive PPO plan in-network design provisions
- While high tech imaging site-of-care steerage is already in place with the GHIP, the above proposal furthers the copay spread between freestanding and hospital-based outpatient facilities to differentiate between basic imaging and high tech imaging

<sup>1</sup> Savings estimates based on assumed utilization; estimates provided on 9/6/2017. Savings for active and pre-65 retiree populations only.

<sup>2</sup> Aetna commented that high tech imaging services yield <0.15% claims savings. 0.08% savings assumed.

<sup>3</sup> Lab savings estimated from initial projection provided by Aetna and Highmark.

# Aetna/Highmark site-of-care steerage

## Estimated savings summary – Design 3

Type of service	Current (Aetna HMO/ Comprehensive PPO In-network)	Proposed Design 3	Aetna HMO Annual Claim Savings <sup>1</sup>		Total Savings Opportunity	Highmark Comprehensive PPO (In-network design) Annual Claim Savings <sup>1</sup>		Total Savings Opportunity
			(%)	(\$)		(%)	(\$)	
Basic imaging services (e.g., X-rays, ultrasounds)	<ul style="list-style-type: none"> <li>Outpatient facility: \$20 copay</li> </ul>	<ul style="list-style-type: none"> <li>Outpatient facility, freestanding: \$20 copay</li> <li>Outpatient facility, hospital-based: \$55 copay</li> </ul>	0.25%	\$0.4m	<b>\$1.0m</b> (\$0.6m general fund)	0.41%	\$1.6m	<b>\$2.2m</b> (\$1.4m general fund)
High tech imaging services (e.g., MRI, CT scans)	<ul style="list-style-type: none"> <li>Outpatient facility, freestanding: \$0 copay</li> <li>Outpatient facility, hospital-based: \$35 copay</li> </ul>	<ul style="list-style-type: none"> <li>Outpatient facility, freestanding: \$20 copay</li> <li>Outpatient facility, hospital-based: \$70 copay</li> </ul>	0.10% <sup>2</sup>	\$0.1m		0.09%	\$0.4m	
Outpatient lab services	<ul style="list-style-type: none"> <li>Any lab: \$10 copay</li> </ul>	<ul style="list-style-type: none"> <li>Preferred lab (Quest/LabCorp): \$10 copay</li> <li>All other labs: \$30 copay</li> </ul>	0.30% <sup>3</sup>	\$0.5m		0.08% <sup>3</sup>	\$0.2m	

### Combined Aetna/Highmark Total Annual Savings Opportunity – Design 3: **\$3.2m**

- Savings estimates assume that these changes are applicable only to Aetna HMO plan and Highmark Comprehensive PPO plan in-network design provisions
- While high tech imaging site-of-care steerage is already in place with the GHIP, the above proposal furthers the copay spread between freestanding and hospital-based outpatient facilities to differentiate between basic imaging and high tech imaging

<sup>1</sup> Savings estimates based on assumed utilization; estimates provided on 9/6/2017. Savings for active and pre-65 retiree populations only.

<sup>2</sup> Aetna commented that high tech imaging services yield <0.20% claims savings. 0.10% savings assumed.

<sup>3</sup> Lab savings estimated from initial projection provided by Aetna and Highmark.

# Aetna/Highmark site-of-care steerage

## Estimated savings summary – Design 4

Type of service	Current (Aetna HMO/ Comprehensive PPO In-network)	Proposed Design 4	Aetna HMO Annual Claim Savings <sup>1</sup>		Total Savings Opportunity	Highmark Comprehensive PPO (In-network design) Annual Claim Savings <sup>1</sup>		Total Savings Opportunity
			(%)	(\$)		(%)	(\$)	
Basic imaging services (e.g., X-rays, ultrasounds)	<ul style="list-style-type: none"> <li>Outpatient facility: \$20 copay</li> </ul>	<ul style="list-style-type: none"> <li>Outpatient facility, freestanding: \$25 copay</li> <li>Outpatient facility, hospital-based: \$60 copay</li> </ul>	0.30%	\$0.5m	<b>\$1.3m</b> (\$0.8m general fund)	0.48%	\$1.8m	<b>\$2.7m</b> (\$1.7m general fund)
High tech imaging services (e.g., MRI, CT scans)	<ul style="list-style-type: none"> <li>Outpatient facility, freestanding: \$0 copay</li> <li>Outpatient facility, hospital-based: \$35 copay</li> </ul>	<ul style="list-style-type: none"> <li>Outpatient facility, freestanding: \$25 copay</li> <li>Outpatient facility, hospital-based: \$75 copay</li> </ul>	0.20%	\$0.3m		0.13%	\$0.5m	
Outpatient lab services	<ul style="list-style-type: none"> <li>Any lab: \$10 copay</li> </ul>	<ul style="list-style-type: none"> <li>Preferred lab (Quest/LabCorp): \$10 copay</li> <li>All other labs: \$35 copay</li> </ul>	0.35% <sup>2</sup>	\$0.5m		0.09% <sup>2</sup>	\$0.4m	

### Combined Aetna/Highmark Total Annual Savings Opportunity – Design 4: **\$4.0m**

- Savings estimates assume that these changes are applicable only to Aetna HMO plan and Highmark Comprehensive PPO plan in-network design provisions
- While high tech imaging site-of-care steerage is already in place with the GHIP, the above proposal furthers the copay spread between freestanding and hospital-based outpatient facilities to differentiate between basic imaging and high tech imaging

<sup>1</sup> Savings estimates based on assumed utilization; estimates provided on 9/6/2017. Savings for active and pre-65 retiree populations only.

<sup>2</sup> Lab savings estimated from initial projection provided by Aetna and Highmark.

# Centers of excellence: medical carriers vs. carve-out vendors

Category	Medical Carriers	Carve-Out Vendors
<b>General Overview</b>	<ul style="list-style-type: none"> <li>▪ <b>Pro:</b> Established practices, networks, and offerings</li> <li>▪ <b>Con:</b> Less flexibility and innovation. Lack of consistent alignment between COE and other high-performance network strategies</li> </ul>	<ul style="list-style-type: none"> <li>▪ <b>Pro:</b> Newer entrants to market allows for more flexibility, room for innovation</li> <li>▪ <b>Con:</b> Execution risk associated with less-established vendors. Variation in medical carrier willingness to partner</li> </ul>
<b>Conditions Covered</b>	<ul style="list-style-type: none"> <li>▪ Generally cover a wider range of conditions and procedures, including maternity, infertility and cancer</li> </ul>	<ul style="list-style-type: none"> <li>▪ Covered conditions and procedures are more limited, although some are in development</li> </ul>
<b>Provider Quality + Selection Criteria</b>	<ul style="list-style-type: none"> <li>▪ Most plans are focused on quality of facility with re-credentialing every 1-3 years</li> <li>▪ Combination of quality, efficiency and volume evaluation, based on variety of internal criteria and public credentialing data sources - e.g. NCQA, CAQH, Joint Commission, etc.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Some are more focused on provider/surgeon quality with more frequent monitoring</li> <li>▪ Combination of quality, efficiency and volume evaluation, based on public credentialing data sources - e.g. NCQA, CAQH, Joint Commission, etc.</li> <li>▪ Methodology and capability vary by vendor – some utilize advanced analytics, for example multi-variant risk-adjustment</li> </ul>
<b>Concierge / Care Coordination</b>	<ul style="list-style-type: none"> <li>▪ Generally less robust than carve-out vendors; however, support varies by carrier and condition (e.g. transplants have more in-depth support)</li> <li>▪ Some after-hours coverage available, but varies by carrier</li> </ul>	<ul style="list-style-type: none"> <li>▪ More robust with concierge-centric approach including appointment scheduling, record management, travel and lodging support and surgeon to PCP coordination</li> <li>▪ After-hours coverage somewhat more limited than medical carriers</li> </ul>
<b>Steerage Capabilities</b>	<ul style="list-style-type: none"> <li>▪ Able to support benefit differentials, although may require a buy-up fee</li> </ul>	<ul style="list-style-type: none"> <li>▪ Able to support a variety of steerage approaches including benefit differentials, cash incentives</li> </ul>
<b>Integration w/ Medical Carriers</b>	<ul style="list-style-type: none"> <li>▪ N/A</li> </ul>	<ul style="list-style-type: none"> <li>▪ Experience integrating with major medical carriers varies widely by vendor and TPA</li> </ul>
<b>Financials</b>	<ul style="list-style-type: none"> <li>▪ Often no separate fee is assessed for COE, but some medical carriers have varied fees by condition</li> <li>▪ Little or no standard performance guarantees around service or ROI</li> <li>▪ Typically not willing to provide warrantees</li> </ul>	<ul style="list-style-type: none"> <li>▪ Typically PEPM and/or percentage of case rate or savings assessed</li> <li>▪ Willing to guarantee ROI in certain circumstances</li> <li>▪ Two of three vendors are willing to provide warrantees</li> </ul>

## Aetna and Highmark COE criteria

- Aetna COE definition – facilities that have demonstrated high levels of quality and cost efficiency performing certain procedures
  - **Institutes of Quality** – Bariatric, Cardiac, Orthopedic (joint replacement and spinal surgery)
  - **Institutes of Excellence** – Transplants (organ and bone marrow), Infertility Treatment
- Highmark COE definition – facilities that deliver high-quality care and superior outcomes for high-risk, high-cost surgical procedures (“Blue Distinction Specialty Care” nationwide quality designation)
  - Specialty areas – Bariatric, Cancer (rare and complex), Cardiac, Maternity, Orthopedic – Knee & hip replacement, Orthopedic – Spinal surgery, Transplants
  - **Blue Distinction Centers (BDC)** – demonstrated quality care, treatment expertise and, overall, better patient results
  - **Blue Distinction Centers+ (BDC+)** – offer more affordable care in addition to having demonstrated quality care, treatment expertise, and, overall, better patient results

# Aetna COEs in Delaware and nearby states<sup>1</sup>

	Within Delaware	Within nearby states (up to 100 mile radius)
<b>Cardiac</b>	None in Delaware	<b>Maryland</b> Baltimore-area facilities – 5 Other Maryland facilities – 1 ■ Including: Peninsula Regional Medical Center – Salisbury, MD  <b>New Jersey</b> Northern-area facilities – 1 Other New Jersey facilities – 1  <b>Pennsylvania</b> Philadelphia/Southern NJ-area facilities – 1 Other Pennsylvania facilities – 5  <b>Washington, D.C.</b> D.C. and surrounding areas – 2
<b>Orthopedic / Spine</b>	<b>Christiana Care – Wilmington, DE</b>	<b>Maryland</b> Baltimore-area facilities – 9 Other Maryland facilities – 0  <b>New Jersey</b> Northern-area facilities – 0 Other New Jersey facilities – 0  <b>Pennsylvania</b> Philadelphia/Southern NJ-area facilities – 8 Other Pennsylvania facilities – 7  <b>Washington, D.C.</b> D.C. and surrounding areas – 4

1. Facilities that are designated as COEs for multiple clinical areas (i.e., cardiac and orthopedic/spine) are counted in each applicable clinical area above.

# Highmark COEs in Delaware and nearby states<sup>1</sup>

	Within Delaware	Within nearby states (up to 100 mile radius)
<b>Cardiac</b>	<b>Bayhealth Hospital</b> – Dover DE <b>Beebe Medical Center</b> – Lewes, DE <b>Christiana Care</b> – Newark, DE	<b>Maryland</b> Baltimore-area facilities – 1 Other Maryland facilities – 1 <ul style="list-style-type: none"> <li>• Peninsula Regional Medical Center – Salisbury, MD</li> </ul> <b>Pennsylvania</b> Philadelphia-area facilities – 7 Other PA facilities – 15 <b>Washington, D.C.</b> D.C. and surrounding area – 3
<b>Orthopedic</b>	None in Delaware	<b>Maryland</b> Baltimore-area facilities – 11 Other Maryland facilities – 7 <ul style="list-style-type: none"> <li>• Including: Peninsula Regional Medical Center – Salisbury, MD</li> </ul> <b>Pennsylvania</b> Philadelphia-area facilities – 13 (including 2 in Southern NJ) Other PA facilities – 17 <b>New Jersey</b> Other NJ facilities – 2 <b>Washington, D.C.</b> D.C. and surrounding area – 6
<b>Spine</b>	<b>Beebe Medical Center</b> – Lewes, DE <b>Christiana Care</b> – Newark, DE	<b>Maryland</b> Baltimore-area facilities – 8 Other Maryland facilities – 4 <ul style="list-style-type: none"> <li>• Including: Peninsula Regional Medical Center – Salisbury, MD</li> </ul> <b>Pennsylvania</b> Philadelphia-area facilities – 9 (including 1 in Southern NJ) Other PA facilities – 10 <b>Washington, D.C.</b> D.C. and surrounding area – 4

1. Facilities that are designated as COEs for multiple clinical areas (i.e., cardiac and orthopedic/spine) are counted in each applicable clinical area above.

## Centers of excellence

### Estimated savings summary

Carrier	Annual Claim Savings (%)	Annual Claim Savings (\$)	Annual Claim Savings General Fund (\$)
Aetna	0.90%	\$1.4m	<b>\$0.9m</b>
Highmark	0.93%	\$3.6m	<b>\$2.3m</b>

**Total Annual Savings Opportunity, General Fund: **\$3.2m****

- Modeling above assumes adoption of steerage to COEs for ALL applicable cardiac, knee/hip and spinal procedures
- Savings attributable to COE benefit design driven by plan design changes (increased member cost sharing at non-COE facilities) and improvements in quality associated with increased COE use
  - Roughly \$0.9m of the \$1.6m savings in FY18 attributable to plan design cost shifting, assuming that a portion of members use non-COE facilities despite the higher cost sharing—remaining savings (\$0.7m) related to improved quality standards of COE-designation
  - Benefit differential will drive additional utilization of COE facilities, improving quality of care and reducing GHIP long term costs
- Member disruption will vary based on procedure, education and specific provider

General Fund split based on GHIP enrollment distribution by agency/department as of February 2017 as reported by Truven and FY17 premium levels  
 List of COE facilities (within 100 miles of DE) for Aetna and Highmark are located within the appendix on pages 37 and 38, respectively  
 Savings for active and pre-65 retiree populations only

# Aetna centers of excellence

## Estimated savings

	Current	Proposed	Annual Claim Savings <sup>1</sup>	
			(%)	(\$)
<b>Cardiac</b> <ul style="list-style-type: none"> <li>Coronary artery bypass graft surgery</li> <li>Heart valve surgery</li> <li>Cardiac medical intervention (i.e. Angioplasty)</li> <li>Rhythm (pacemakers and ICD)</li> </ul>	<ul style="list-style-type: none"> <li>Inpatient Hospital, all facilities (in-network)</li> </ul> <b>CDH Gold</b> Covered at 90%, after \$1,500 deductible  <b>HMO</b> Covered at 100%, after \$100 per day copay for the first two days per confinement, and 100% no copay thereafter	<ul style="list-style-type: none"> <li>Inpatient Hospital, <b>COE Facility</b> (in-network)</li> </ul> <b>CDH Gold</b> Covered at 90% after \$1,500 deductible  <b>HMO</b> Covered at 100%, after \$100 per day copay for the first two days per confinement, and 100% no copay thereafter  <ul style="list-style-type: none"> <li>Inpatient Hospital, <b>Non-COE Facility</b> (in-network)</li> </ul> <b>CDH Gold</b> Covered at <b>75%</b> after \$1,500 deductible  <b>HMO</b> Covered at <b>75%</b> with no deductible and no copay	0.90%	\$1.4m (\$0.4m general fund second half FY18)
<b>Orthopedic/spine</b> <ul style="list-style-type: none"> <li>Knee replacements</li> <li>Hip replacements</li> <li>Spine surgery</li> </ul>				

- Above designs create a meaningful spread between COE and non-COE facilities
- Services rendered at non-COE facilities were modeled at 75% coinsurance after the applicable deductible
  - Member coinsurance would accumulate towards total out-of-pocket maximum for cardiac and orthopedic procedures listed above, at COE and non-COE facilities

1. Estimates provided by Aetna on 7/26/2017. Savings for active and pre-65 retiree populations only.

# Highmark centers of excellence

## Estimated savings

	Current	Proposed	Annual Claim Savings <sup>1</sup>	
			(%)	(\$)
<b>Cardiac</b> <ul style="list-style-type: none"> <li>Coronary artery bypass graft surgery</li> <li>Heart valve surgery</li> <li>Angioplasty</li> </ul>	<ul style="list-style-type: none"> <li>Inpatient Hospital, all facilities (in-network)</li> </ul> <b>Comprehensive PPO</b> Covered at 100%, after \$100 per day copay for the first two days per confinement, no deductible  <b>First State</b> Covered at 90% for unlimited days, after \$500 deductible <sup>2</sup>  <b>POS</b> Covered at 90%, no deductible	<ul style="list-style-type: none"> <li>Inpatient Hospital, <b>COE Facility</b> (in-network)</li> </ul> <b>Comprehensive PPO</b> Covered at 100%, after \$100 per day copay for the first two days per confinement, no deductible  <b>First State</b> Covered at 90% for unlimited days, after \$500 deductible <sup>2</sup>  <b>POS</b> Covered at 90%, no deductible  <ul style="list-style-type: none"> <li>Inpatient Hospital, <b>Non-COE Facility</b> (in-network)</li> </ul> <b>Comprehensive PPO</b> Covered at <b>75%</b> , after \$100 per day copay for the first two days per confinement, no deductible  <b>First State</b> Covered at <b>75%</b> for unlimited days, after \$500 deductible <sup>2</sup>  <b>POS</b> Covered at <b>75%</b> , no deductible	0.93%	\$3.6m (\$1.2m general fund second half FY18)
<b>Orthopedic</b> <ul style="list-style-type: none"> <li>Knee replacements</li> <li>Hip replacements</li> </ul>				
<b>Spine</b> <ul style="list-style-type: none"> <li>Discectomy</li> <li>Fusion</li> <li>Decompression</li> </ul>				

- Above designs create a meaningful spread between COE and non-COE facilities
- Services rendered at non-BDC facilities were estimated at 75% coinsurance after the applicable deductible
- The above includes estimated savings resulting from lower readmissions, higher quality of care, etc.

1. Estimates provided by Highmark on 8/7/2017. Savings for active and pre-65 retiree populations only.

2. Deductible shown for individual, family deductible \$1,000

3. 75% coverage for Bariatric surgery performed at non-BDC facility does not accumulate towards the total out-of-pocket maximum as it is not an essential health benefit under the ACA

# Premium cost share savings – active and pre-65 retirees

## Employee/pensioner impact

- The following table illustrates the change in employee/pensioner contributions for each shift in active/pre-65 retiree cost share
  - Assumes a uniform increase across all plans (i.e., a 1% increase in active/pre-65 retiree cost share increases current contributions for all plans and coverage tiers by 9.4%)

Employee/Pensioner Monthly Contribution	FY18 Status Quo Contribution	+1% Increase		+2% Increase		+3% Increase	
		Contribution	\$ Difference	Contribution	\$ Difference	Contribution	\$ Difference
<b>First State Basic<sup>1</sup></b>	<b>4.00%</b>	<b>4.38%</b>		<b>4.76%</b>		<b>5.13%</b>	
Employee	\$27.84	\$30.46	\$2.62	\$33.07	\$5.23	\$35.69	\$7.85
Employee & Spouse	\$57.52	\$62.92	\$5.40	\$68.33	\$10.81	\$73.73	\$16.21
Employee & Child(ren)	\$42.26	\$46.23	\$3.97	\$50.20	\$7.94	\$54.17	\$11.91
Family	\$71.92	\$78.68	\$6.76	\$85.44	\$13.52	\$92.19	\$20.27
<b>CDH Gold<sup>1</sup></b>	<b>5.00%</b>	<b>5.47%</b>		<b>5.94%</b>		<b>6.41%</b>	
Employee	\$35.98	\$39.36	\$3.38	\$42.74	\$6.76	\$46.12	\$10.14
Employee & Spouse	\$74.58	\$81.59	\$7.01	\$88.60	\$14.02	\$95.60	\$21.02
Employee & Child(ren)	\$54.96	\$60.12	\$5.16	\$65.29	\$10.33	\$70.45	\$15.49
Family	\$94.78	\$103.69	\$8.91	\$112.59	\$17.81	\$121.50	\$26.72
<b>HMO<sup>1</sup></b>	<b>6.50%</b>	<b>7.11%</b>		<b>7.72%</b>		<b>8.33%</b>	
Employee	\$47.16	\$51.59	\$4.43	\$56.02	\$8.86	\$60.45	\$13.29
Employee & Spouse	\$99.50	\$108.85	\$9.35	\$118.20	\$18.70	\$127.55	\$28.05
Employee & Child(ren)	\$72.18	\$78.96	\$6.78	\$85.74	\$13.56	\$92.53	\$20.35
Family	\$124.12	\$135.78	\$11.66	\$147.45	\$23.33	\$159.11	\$34.99
<b>PPO<sup>1</sup></b>	<b>13.25%</b>	<b>14.49%</b>		<b>15.74%</b>		<b>16.98%</b>	
Employee	\$105.18	\$115.06	\$9.88	\$124.95	\$19.77	\$134.83	\$29.65
Employee & Spouse	\$218.26	\$238.77	\$20.51	\$259.28	\$41.02	\$279.79	\$61.53
Employee & Child(ren)	\$162.08	\$177.31	\$15.23	\$192.54	\$30.46	\$207.77	\$45.69
Family	\$272.86	\$298.50	\$25.64	\$324.14	\$51.28	\$349.78	\$76.92

<sup>1</sup> Percentages shown represent the employee/pensioner share of plan premium

## Premium cost share savings – Medicfill

- Pensioners eligible for Medicare that retired prior to July 1, 2012 currently pay no premium contributions for the Medicfill plan
- The State can achieve additional savings through elimination of the contribution inequity for these members
  - This change would require these pensioners to pay a contribution equal to 5% of the Medicfill plan premium
- As of January 2017, there were 21,262 pensioners enrolled in Medicfill paying \$0 in contributions
  - 19,611 enrolled in Special Medicfill with Rx
  - 1,651 enrolled in Special Medicfill with no Rx
- The following table illustrates annual savings for elimination of the Special Medicfill contribution inequity:

Plan	Enrollees <sup>1</sup>	Monthly Contribution	Annual Savings by Fund Category <sup>2</sup>			
			General	Non-General	Unaffiliated	Total GHIP
Special Medicfill with Rx	19,611	\$22.96	\$3.4 M	\$1.6 M	\$0.4 M	\$5.4 M
Special Medicfill no Rx	1,651	\$13.00	\$0.2 M	\$0.0 M	\$0.0 M	\$0.2 M
Total	21,262	n/a	\$3.6 M	\$1.6 M	\$0.4 M	\$5.6 M

<sup>1</sup> Based on January 2017 State share percentage counts provided by OMB

<sup>2</sup> Splits calculated using GHIP group percentages based on Truven census and actual Fiscal Year 2016 Premium Contributions and Revenue as reported by OMB Financial Operations/PHRST.

## Plan design savings – Medicfill

- Medicare retirees have minimal medical cost sharing under the current Medicfill plan
  - Most medical services are currently covered at 100%; any increases in cost sharing through deductibles or copays would create first dollar savings for the State
- The State can achieve savings through increased cost sharing for the Medicfill plan in the form of deductibles and/or copays on specific services
  - Adding deductibles to the Medicfill plan would generate savings but may create significant member disruption
  - Adding copays for specific services such as office (OV), emergency room (ER) and/or inpatient (IP) visits can also generate savings and may be more palatable for retirees
- The following table illustrates annual savings for various plan design alternatives for the Medicfill plan:

Plan Design	Annual Savings by Fund Category <sup>1</sup>			
	General Fund	Non-General Fund	Unaffiliated	Total GHIP
\$50 Deductible <sup>2</sup>	\$0.4 M	\$0.2 M	\$0.0 M	\$0.6 M
\$250 Deductible <sup>2</sup>	\$2.0 M	\$0.8 M	\$0.2 M	\$3.0 M
\$10 OV Copay	\$2.0 M	\$0.9 M	\$0.1 M	\$3.0 M
\$150 ER Copay	\$1.2 M	\$0.6 M	\$0.2 M	\$2.0 M
\$100 IP Copay <sup>3</sup>	\$0.6 M	\$0.2 M	\$0.2 M	\$1.0 M

<sup>1</sup> Splits calculated using GHIP group percentages based on Truven census and actual Fiscal Year 2016 Premium Contributions and Revenue as reported by OMB Financial Operations/PHRST.

<sup>2</sup> Illustrated deductibles are per member and apply to hospital benefits only (Part A)

<sup>3</sup> \$100 copay per day to a maximum of \$200

## Implementing GHIP changes

### Changing the State's benefits plan year from fiscal to calendar

- Additional requirements of the State to support a plan year change from fiscal year (July 1) to calendar year (January 1):
  - Notify medical plan vendors of intent to shorten Fiscal Year plan year to 6 months (July 1 – December 31), and renegotiate benefit contracts as needed
  - Conduct two Open Enrollment (OE) events in that calendar year (one in the spring, one in the fall) to accommodate enrollment changes for the shortened Fiscal Year plan year as well as the following calendar year plan year
  - Adjust timing of GHIP budget development process to account for plan year differences and the need to move budgeting timeline to a calendar year basis
- Shifting the benefits plan year to a calendar year basis for all other benefits would provide a more integrated, seamless experience for all benefits to be in the same cycle